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ACCESS TO CARE FOR THE ELDERLY

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ABERDEEN, SD

AUGUST 7, 1989

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ACCESS TO HEALTH CARE FOR THE ELDERLY

MONDAY, AUGUST 7, 1989

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Aberdeen, SD.

The committee met, pursuant to notice, at 1:30 p.m., St. Luke's Midland Regional Medical Center, Aberdeen, South Dakota, Hon. Larry Pressler presiding.

Present: Senator Pressler.

OPENING STATEMENT BY SENATOR LARRY PRESSLER

Senator PRESSLER. Good afternoon. Welcome.

Thank you all for attending this official hearing of the Senate Special Committee on Aging. I see many familiar faces, many people who should be introduced who have contributed a great deal—not only to the elderly, but to health care in South Dakota.

We have many health care issues in our State and across the Nation. An example is the excessive cost of health insurance. This week, when I leave Aberdeen, I shall be driving to Buffalo, SD, stopping along the way for listening meetings in Mobridge, McLaughlin, Lemmon, Bison, Isabel, and Buffalo.

I always enjoy that annual trip because I love to see the countryside; it's a beautiful part of our State. However, in no part of the United States are there more problems with the delivery of health care services than in that area, plus Indian reservations.

In many ways, Aberdeen is blessed with a number of excellent health care professionals. I am well aware of the quality of the institutions here, because two of my sisters took their registered nurse training in this city.

But there are still great problems. We are going to talk today about some of those problems: the price of drugs and generally the problems of delivery of care to the elderly.

As a member of the Senate Special Committee on Aging, I fight very hard to try to find the right approach on these matters. Hearings such as this help me to do my job. The transcript helps others understand the rural problems. In Washington, DC, we have some of our biggest battles over urban and rural issues, for example Medicare reimbursement formulas and wage standards that are set without an understanding of the problems in small communities.

We have an outstanding group of witnesses today. We will hear from each of them and put their complete statements in the record. Once the eight witnesses have completed their testimony, we will have time for questions and answers.

I want to thank all of you who have taken the time to come because by coming you have shown interest and support for working on some of the severe problems that we have. I also want to thank Dale Stein and Byron Peterson of the St. Luke's Midland Regional Medical Center for their assistance in helping make the arrangements.

A transcript of the hearing will be made available to all members of the Senate Special Committee on Aging as well as my other colleagues in the U.S. Senate.

I know there are many technical problems with Medicare deductibles and coinsurance. I could go into those in more detail but I think I will let our witnesses do so. We will be hearing about the cost of prescription drugs, questions on long-term care in some of our nursing homes and public policy on access to health and social care.

At this point, I will place my own statement in the record.

[The prepared statement of Senator Pressler follows:]

OPENING STATEMENT BY SENATOR LARRY PRESSLER
SENATE SPECIAL COMMITTEE ON AGING
HEARING ON

ACCESS TO CARE FOR THE ELDERLY
ABERDEEN, SD
AUGUST 7, 1989

I welcome each of you to this official hearing of the U.S. Senate Aging Committee. A transcript of this hearing will be made available to all members of the Committee as well as my other colleagues in the U.S. Senate. Written statements and comments from all who are in attendance today are welcome and may be submitted for the record.

I want to begin by thanking Dale Stein and Byron Peterson of St. Lukes Midland Regional Medical Center for their assistance with the arrangements for today's hearing here at the hospital.

This hearing is an opportunity to examine the problems the elderly in obtaining adequate health care and accessing other resources. To live a good life, people need adequate food, clothing, shelter, medical care and financial resources. Society is constantly changing, and this affects how the basic needs of the elderly are met. For example, when bus service was discontinued between Aberdeen and Ipswich the elderly had to adjust and find other ways of meeting their needs. That could affect the older persons social relationships as well as access to services. If a town loses its doctor, or a hospital closes or the local meals-on-wheels program is discontinued, the loss of those services affects the elderly most of all. It is important that all of us become more sensitive to these situations.

The elderly are very concerned about the availability of affordable health care. That is why they strongly support the Medicare program. However, Medicare does not guarantee access to health-care services. If the closest clinic is located miles from an individual's home or the local hospital has closed and the older person cannot drive to another town, then Medicare doesn't help.

Another problem is paying for deductibles and coinsurance. Today a person on Medicare is asked to pay a $560 deductible for hospital care and a $1,370 deductible and coinsurance for physician and outpatient services. I know many elderly who have a supplemental or medigap policy to pay for those deductibles and coinsurance. However, a significant number of the elderly cannot afford those policies. What happens to them when they need care? What happens if the attending physician does not accept as payment in full what Medicare pays? I am pleased that our panel of experts includes two physicians, Dr. Richard Mulder and Dr. Stephan Schroeder, and a hospital administrator, Gerald Huss. Their testimony will help shed more light on those issues.

Prescription drug prices continue to escalate, and this has an obvious impact on the elderly. During a recent Senate Aging Committee hearing on the cost of prescription drugs, I heard that the problem is not the fault of the small town independent retail pharmacy. In fact, this issue is so complicated that future hearing are planned to unravel the problem. Many South Dakotans have told me that high prescription drug costs are a serious problem for them. I look forward to hearing more about this from Ray Hoppenan (HOP-EN-AN), a registered pharmacist.

Long-term care is often synonymous with nursing-home care. However, long-term care is not limited to nursing-home care. Long-term care includes a variety of living arrangements for older people as their needs change. Today the need for many alternatives is important. We are an aging nation. People are living longer. As we age, nursing-home care, as an alternative, is essential. However, there are other options, including at-home care with social support services, congregate housing, and personal-care homes. The need for alternative living arrangements will continue to grow along with our aging population.

Another need expressed by many seniors is affordable nursing-home insurance. Unfortunately, many private policies are very expensive and others have limited coverage. Congress will be examining this situation and exploring possible remedies. Issues are the extent of coverage and financing mechanisms. Two experts in long-term care and aging, Wayne Muth and Gail Farris, will help us better understand the nursing-home insurance picture.

Public policy on access to health and social care is a good only if it really helps people. Frequent communication between policymakers and the public, providers and consumers, is essential to making good policy. As a policymaker, I welcome the ideas and views of fellow South Dakotans. You help me understand the specific needs of those who live and work with the elderly. Peg Lamont and Lucille Stafford, who understand the needs of the elderly better than I, will share their views with us today. Peg and Lucille know the problems encountered by the elderly on a daily basis for example, the need for congregate meals and transportation, problems with Social Security and the special problems of the rural, poor elderly.

Our hearing will examine all of these questions from different perspectives. I look forward to hearing from our witnesses. At this time, I would like to introduce our first witness, Dr. Richard Mulder.

Senator PRESSLER. Our first witness is Dr. Richard Mulder, a certified family physician who is in solo practice in Ivanhoe, MN. He is known in this area as an expert in family practice. He was awarded the Bush Clinical Fellowship to do extensive study in geriatric medicine and rural health care. He has driven quite a distance to be here today, about 200 miles

We thank you very much, Dr. Mulder.

STATEMENT OF RICHARD D. MULDER, M.D., IVANHOE, MN

Dr. MULDER. I want to thank Senator Pressler for inviting me here, and certainly thank you folks for coming here. It looks like we're running out of chairs.

I've talked to a lot of senior groups in the past and I can see a lot of you have some real important questions and concerns for me. I hope we will have time to answer those later on.

I got my pharmacy degree at Brookings at South Dakota State. My friend Ray Hopponen is here. He was dean when my son started pharmacy there. Then I went to medical school at the University of South Dakota and interned at McKennan Hospital, in Sioux Falls. I'm from a small town in Iowa, and presently have been practicing in a small town in Minnesota right on the South Dakota border. So I'm an honorary South Dakotan, okay?

I've been interested in rural health care since I have been alone and the only physician in Ivanhoe for 24 years. We have been seeing the same problems I think most of you have been seeing. I want to talk a little bit about access to health care in our country today.

There are really three problems in the health care access area that exist.

First, we have a real problem in that many areas of this country simply do not have a doctor available and their hospitals have closed. Over 800 hospitals have closed in this country in the last 9 years. We had close to 7,000 hospitals in 1980 and we have only about 6,200 hospitals left and only 5,800 community hospitals.

The second problem is that we have about 39 million people who are uninsured or underinsured. They can't afford the insurance that they have to have in order to have comprehensive health care.

The third problem in access that we are having today is rationing of health care. I will talk a little more about that later. At the present time, only the very affluent in this country can afford 100 percent quality comprehensive health care, including dialysis and organ transplants. It's getting to be a very expensive proposition in the future.

This is the only country in the world where we have the availability of that health care and the freedom for patients to choose their hospital, to choose their physicians, and the freedom for physicians to choose their patients.

The only way other countries have been able to take care of the tremendous cost of their health care system is to ration health care. I have investigated every other country that I can get information about, and the bottom line is that they cut costs only by rationing health care. This is done by reducing the availability of physicians and hospitals, by decreasing the numbers and kinds of

procedures that are available, and in some cases by withholding medical treatment for certain diseases. This has been done for the most part against the wishes of physicians.

Most of these countries also have adopted the principle of distributed justice. What that means is that once there is rationing of care (in the State of Oregon they just passed a law to ration care, they will not do organ transplants in the State and Medicaid will not pay for organ transplants) then they adopt this principle of distributed justice that says if Medicaid can't pay for a liver transplant in a 2-year-old then nobody else can have a liver transplant.

So rationing now is even affecting the very affluent, the people that can afford all this care and organ transplants. Rationing will pretty soon make it impossible for everyone to get complete health care.

When we talk about what the proper definition of health care is, during World War II, we had a term that we called the "first golden hour." In the first 60 minutes, if we can get to a patient that has a severe injury or illness, we have a better result in saving that patient's life or reducing disability.

Right after the Second World War, our Congress decided that people should have better access to health care and they passed what's called the Hill-Burton Act. With that act, of the 7,000 hospitals we have left, we built more than 4,500 of the hospitals in this country. They were built from 1950 to 1973.

They also said at that time that no person should live more than 20 miles from a hospital or health care access. Now Congress is doing just the opposite of that by closing 800 hospitals. Of the 168 hospitals in Minnesota, 91 were built by this Hill-Burton Act.

Then in 1974, the National Health Planning and Resources Development Act established health systems agencies and certificate of need plans. But they also said at that time that no person should live more than 30 miles from acute care access or hospitals.

I have been on various committees including the National Rural Health Task Force Committee for the American Academy of Family Physicians. We are saying that we don't think any person in this country should live more than 30 minutes away from acute health care.

In Minnesota we have 18,000 people who now do not have that access. Just in the last 2 months, two more hospitals closed. A total of 10 hospitals have closed in our State recently. If the hospitals that we think are in trouble are going to close in the future, within the next 3 years we are going to have another 19,000 patients that do not have proper access to health care.

In South Dakota we have 56 hospitals. This year, 14 of those hospitals are going to have an 18.4 percent net loss from treating Medicare patients. We project for next year, if we don't do something about the $3 billion cut that the Government wants to put on top of hospitals and physicians, those 14 hospitals will have about a 25 percent net loss from treating Medicare patients.

Statistically, we find that if a hospital loses money 3 or 4 years out of 4 years, that they are closed within 3 more years. We can project right now that within the next 4 or 5 years, 14 hospitals in South Dakota will close, unless there is something done, and that is what Senator Larry is here to do.

The same situation I think exists for all of rural America. Texas has been hit the worst. I think they have had over 46 hospitals close down. The biggest problem with our rural hospitals here in South Dakota and in all of rural America is that they are not being reimbursed adequately. Every senior citizen in this country has paid exactly the same rate for Social Security tax. That Social Security tax allows him to receive benefits for Part A Medicare, or treatment in hospitals.

Everybody pays the same rate, however, rural hospitals, and almost all the hospitals in this State are reimbursed 37 percent less than are the big city hospitals. They treat exactly the same disease, but because of what is called a DRG, or diagnostic related group, they are paid by the diagnosis only. So they get paid 37 percent less here in Aberdeen, or elsewhere in this State, than they do in New York or the larger hospitals in the country.

We all have to keep up with the technology that we have, and it is becoming almost impossible for small hospitals to do that because of their low reimbursement formulas.

Also, every senior citizen in this country pays exactly the same premium for their Part B Medicare, $31.90 a month. Except that urban senior citizens, on a national average, are reimbursed twice as much than you folks are.

On the east coast (Miami, New York, and large cities like that), the seniors are reimbursed four times as much as you are, and yet they pay exactly the same premium for their Part B benefit. Part B, you know, pays for your physician's office calls and for your physician's care while you are in the hospital. This has resulted in you paying premiums that essentially subsidize the health care for those senior citizens on the east coast.

I think the reduction in reimbursement that we have had in the last 8 years has resulted in the problems of access that we are having now here in the Midwest and in South Dakota. I don't think that this is fair to our senior citizens. I think the Federal Government, by adopting these rules, is treating our senior citizens out here in rural America as second class citizens.

Many rules are being considered in Congress right now. The formulas for them are pretty good, but they aren't going to go into effect for about 5 years, and I am concerned that by then it's going to be too late to reopen hospitals that have already closed. To correct this situation, I would recommend that some type of reconciliation of these bills be adopted immediately, and be implemented immediately. They want to phase it in over 5 years and that's going to be too late. I think the reimbursement issues for both Part A and Part B Medicare have to be equal nationwide. It just is not fair to charge you the same taxes for Social Security, the same taxes for your Medicare Part B premiums, and then reimburse you one-half or one-fourth of what you should have.

The second problem that we have in access to health care is the fact that before World War II, we could charge patients different amounts. We were able to take care of the people who did not have insurance or the finances to be able to help take care of the health care cost, by charging the ones that had the money more.

Since we got our third-party payer system on line, we were told we have to charge everybody the same. Now in order for us to con-

tinue to treat these 39 million Americans without insurance, and not get paid for it, we have to charge everybody else more, or cost shift.

The system is going to cost a great deal, but somebody has to pay. And because we have cost shift, third-party payers are ending up paying more, especially businesses—up to 8 percent of their expenses now are for health care. They are yelling the loudest because they know they are subsidizing the care of these 39 million Americans.

The only answer that I can see for these 39 million Americans is to increase the amount of Federal funding to take care of them. It has to come from some place. It just can't come from cost shifting like it has been done in the past.

We talked earlier about rationing health care. There are three kinds of systems for rationing. One is the price type of rationing. This is where insurance is sometimes so expensive people can't afford it. Also they have to pay high deductibles and high co-insurance.

The second type of rationing we call implicit rationing. This is the DRG program I just mentioned, where the Federal Government pays hospitals different rates for taking care of an illness. They don't take care into consideration a lot of things—how severe a patient's illness is, how old they are and a lot of other humane things.

So they give us a number of dollars to treat a disease, and since rural America gets 37 percent less, we have to do a much more efficient job than they do in the big city. If we get a patient in one of our rural hospitals that has a very devastating and long-lasting disease, sometimes the expense of that patient in that hospital can be enough to close it up.

The third type of rationing that we are seeing now, and that has been passed in several States (such as Oregon), is explicit rationing. That's where State law says who we can treat and how we have to treat them (at what age hip surgery can be done, that we can't do bypass surgery over age 67; we can't do organ transplants, etc.). This is where they tell us what to do and how to do it. This type of explicit rationing affects everybody's access to health care.

There are a lot of other problems that exist here. When we talk about how much we spend, about 11.4 percent of our gross national product is spent for health care. We are spending 15 percent of our gross national product just to fund our national debt. If we didn't have the national debt we have, we would have twice as much money as we need to fund health care.

Finally, if we are going to continue to have comprehensive, high quality health care and if we are going to make this health care available to everyone in this country, then we are going to have to accept the fact that it is going to cost more money. We are the last country in the world to have the continued freedom for access to physicians and hospitals by all patients.

We, as physicians, can still choose our patients, we can still choose our hospitals and doctors as patients, and we have to be able to continue to practice high quality medicine. When patients come to me it is my responsibility and my duty to do everything right for that patient for his proper treatment and for his comfort.

I have to be my patient's advocate to do what I think is right, no matter what the politics are of third-party payers. The health and welfare of my patients has to be my first consideration. I can't let economics, and politics, or religion, or any other circumstance take preference.

This has been the philosophy of ethical physicians from time immemorial. I have taken an oath to uphold this philosophy and I believe most physicians in this country have done likewise. If the Federal Government continues their present economic philosophy, we not only will see more rationing of care, but we will also see further deterioration of access and quality of that care.

I want to thank you for being so attentive here. I hope everybody could hear me. If you have any questions later on, I'll do what I can to answer them.

Thank you.

[The prepared statement of Dr. Mulder follows:]

MY NAME IS RICHARD D. MULDER. I AM A BOARD CERTIFIED FAMILY PHYSICIAN AND HAVE BEEN IN THE PRIVATE PRACTICE OF FAMILY MEDICINE IN IVNAHOE, MINNESOTA FOR THE PAST 20 YEARS. DURING THAT TIME I HAVE BEEN THE ONLY PHYSICIAN IN IVANHOE AND ALSO THE ONLY PHYSICIAN IN LAKE BENTON WHERE I HAVE A SATELLITE CLINIC. I HAVE A PHARMACY DEGREE FROM SOUTH DAKOTA STATE COLLEGE AT BROOKINGS, SOUTH DAKOTA AND A MEDICAL DEGREE FROM THE UNIVERSITY OF SOUTH DAKOTA AT VERMILLION, SOUTH DAKOTA AND HAVE INTERNED AT MCKENNAN AT SIOUX FALLS, SOUTH DAKOTA. MY MD DEGREE WAS FROM THE UNIVERSITY OF IOWA.

I WANT TO THANK YOU FOR THE OPPORTUNITY OF GIVING YOU SOME OF MY THOUGHTS ABOUT ACCESS TO HEALTH CARE IN OUR COUNTRY. THERE ARE THREE PROBLEMS WITH RESPECT TO ACCESS TO HEALTH CARE THAT EXIST TODAY. FIRST, WE HAVE A RURAL PROBLEM NOW WITH MANY CITIES OF THIS COUNTRY NOT HAVING A PHYSICIAN OR HOSPITAL AVAILABLE TO THEM FOR ANY TYPE OF HEALTH CARE. SECOND, WE HAVE APPROXIMATELY 39 MILLION AMERICANS WHO ARE UNDERINSURED OR UNINSURED AND FINANCIALLY DO NOT HAVE ACCESS TO PROPER HEALTH CARE. THIRDLY, WE ARE HAVING VARIABLE LEVELS OF RATIONING WHICH ARE CAUSING A REDUCTION IN ACCESS TO HEALTH CARE TO MOST EVERY ONE ELSE IN THE COUNTRY.

AT THE PRESENT TIME, ONLY THE VERY AFFLUENT ARE NOW ABLE TO AFFORD 100% COMPREHENSIVE HEALTH CARE INCLUDING ORGAN TRANSPLANTS. BUT EVEN THIS AVAILABILITY IS BEING THREATENED BECAUSE OF RATIONING. THE AVAILABILITY OF COMPREHENSIVE QUALITY HEALTH CARE IS VERY EXPENSIVE. THE UNITED STATES IS THE ONLY COUNTRY IN THE WORLD THAT HAS HAD THAT AVAILABILITY, AND THE FREEDOM FOR PATIENTS TO CHOOSE THEIR PHYSICIANS AND HOSPITALS AND THE FREEDOM OF PHYSICIANS TO CHOOSE THEIR PATIENTS. IN EVERY OTHER COUNTRY IT HAS BEEN DETERMINED BY THEIR SOCIETY THAT THEY DID NOT WANT TO PAY THE PRICE FOR THAT FREEDOM OR THAT ACCESS. IT IS A FACT THAT THE ONLY WAY TO CONTROL MEDICAL COST IN EVERY OTHER COUNTRY HAS BEEN TO RATION HEALTH CARE. THIS IS DONE BY DECREASING AVAILABILITY OF PHYSICIANS AND HOSPITALS, BY DECREASING THE NUMBER AND KINDS OF PROCEDURES THAT ARE DONE, AND FOR SOME DISEASES, TO WITHHOLD ANY KIND OF MEDICAL TREATMENT. IN GENERAL THIS HAS BEEN DONE AGAINST THE WISHES AND HOPES OF PHYSICIANS. IN MANY WESTERN TYPE COUNTRIES, HOWEVER, THEIR GOVERNMENTS HAVE HAD DIFFERENT OPINIONS. THE PRINCIPLE OF THIS DISTRIBUTED JUSTICE SEEMS TO HAVE BEEN PARAMOUNT IN MOST COUNTRIES AND IT IS NOW THAT PRINCIPLE IS BEING CONSIDERED BY OUR GOVERNMENT. THIS MEANS IF THAT A PROCEDURE CANNOT BE OFFERED TO EVERYONE WHO NEEDS IT BECAUSE OF RATIONING, THEN IT HAS TO BE FORBIDDEN TO EVERYONE, INCLUDING THOSE THAT ARE PREPARED TO FINANCE IT THEMSELVES. THEREFORE, EVEN THE VERY AFFLUENT IN THIS COUNTRY ARE LOSING ACCESS TO COMPREHENSIVE CARE. WHAT IS PROPER DEFINITION TO ACCESS TO HEALTH CARE? DURING WORLD WAR II WE BECAME AWARE OF WHAT WE NOW CALL THE "FIRST GOLDEN HOUR". WHAT THIS MEANS IS THAT DURING THE FIRST HOUR AFTER A PERSON SUFFERS A CATASTROPHIC EVENT, INJURY, ILLNESS OR ACUTE MEDICAL EMERGENCY, THAT MANY THINGS CAN BE DONE TO SAVE THAT PATIENT'S LIFE AND TO PREVENT DISABILITY. AFTER THAT HOUR THERE IS A SIGNIFICANT DECLINE IN EFFECTIVE MEDICAL CARE.

THE CONGRESS OF THE UNITED STATES IN 1946 SET UP THE HILL BURTON ACT. THEY DECIDED THAT NO HOSPITAL SHOULD BE MORE THAN 40 MILES AWAY FROM ANOTHER HOSPITAL, THEY ALSO DECIDED THAT NO ONE IN THIS COUNTRY SHOULD BE MORE THAN 20 MILES AWAY FROM A MEDICAL FACILITY OR A HOSPITAL. THEY AUTHORIZED FUNDS TO BUILD HOSPITALS AND APPROXIMATELY ONE HALF OF ALL THE 7,000 HOSPITALS THAT WE HAVE IN THIS COUNTRY WERE BUILT DURING THAT PERIOD. OF THE 168 HOSPITALS THAT WE HAVE IN MINNESOTA, 91 WERE BUILT BETWEEN 1950 AND 1973 WITH HILL BURTON FUNDS.

IN 1974 THE NATIONAL HEALTH PLAN AND THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974 ESTABLISHED THE HEALTH SERVICE AGENCY CONCEPT AND CERTIFICATE OF NEED PLAN. DURING THAT TIME, CONGRESS DECIDED THAT NO PERSON IN THIS COUNTRY SHOULD LIVE NO MORE THAN 30 MILES FROM A HOSPITAL OR ACUTE MEDICAL CARE FACILITY. ON VARIOUS RURAL HEALTH CARE COMMITTEES THAT I HAVE BEEN ON WE HAVE ALSO DISCUSSED THIS AND HAVE DECIDED THAT NO PERSON IN THIS COUNTRY SHOULD LIVE NO MORE THAN 30 MINUTES WAY FROM A HOSPITAL. IN MY STATE OF MINNESOTA THERE ARE 18,000 PEOPLE WHO BY THIS DEFINITION DO NOT HAVE ACCESS TO ANY HEALTH CARE. THIS IS A RESULT OF MANY HOSPITAL CLOSURES DURING THE LAST 8 YEARS. TWO MORE HOSPITALS RECENTLY CLOSED AND IF THERE IS NO CHANGE IN THE REIMBURSEMENT TO RURAL HOSPITAL IN THIS COUNTRY, MORE HOSPITALS WILL CLOSE AND 19,000 MORE PEOPLE WILL LACK ACCESS TO MEDICAL CARE. IN SOUTH DAKOTA, 14 OF THE 56 HOSPITALS ARE PREDICTED TO HAVE A NET LOSS OF 18.4% OR MORE FOR 1988 FOR TREATING MEDICAL PATIENTS. WHAT THIS MEANS IS THAT FOR EVERY DOLLAR OF EXPENSE THEY HAVE FOR TREATING MEDICARE PATIENTS, THEY ARE ONLY REIMBURSED ONLY 81.6 CENTS OR LESS. EVEN IF THERE WERE NO CUTS IN REIMBURSEMENTS FOR THESE HOSPITALS, IN 1990 14 OUT OF THE 56 HOSPITALS WILL HAVE AN AVERAGE OF 23.6% OPERATING LOSS. THERE HAS BEEN A TREND IN THIS COUNTRY THAT IF A HOSPITAL LOOSES MONEY, 3 OUT OF 4 YEARS THAT THEY EVENTUALLY WILL CLOSE IN ABOUT 3 MORE YEARS. IF THE TRENDS THAT NOW EXIST IN SOUTH DAKOTA CONTINUE, WE CAN EXPECT UP TO 14 HOSPITALS CLOSING IN THE NEXT FOUR OR FIVE YEARS, AGAIN RESULTING IN SIGNIFICANT REDUCTION IN ACCESS TO HEALTH CARE FOR THE PEOPLE THAT LIVE IN THOSE AREAS.

THE SAME SITUATION EXISTS FOR ALL OF RURAL AMERICA. THE BIGGEST PROBLEM THAT RURAL HOSPITALS IN SOUTH DAKOTA HAVE IS THAT THEY ARE NOT REIMBURSED ADEQUATELY BY THE FEDERAL GOVERNMENT. EVERY SENIOR CITIZEN IN SOUTH DAKOTA HAS PAID EXACTLY THE SAME SOCIAL SECURITY TAX AS DO ALL CITIZENS OF THIS COUNTRY. THAT ENTITLES THEM TO PART "A" MEDICARE FOR TREATMENT IN HOSPITALS FOR THEIR ILLNESSES. HOWEVER, ALMOST ALL THE HOSPITALS IN SOUTH DAKOTA AS WELL AS ALL OF RURAL AMERICA ARE REIMBURSED 37% LESS FOR TREATING THE EXACT SAME DISEASE AS DO HOSPITALS IN THE VERY LARGE CITIES. IS IT IMPOSSIBLE FOR OUR RURAL HOSPITALS TO CONTINUE TO KEEP UP TECHNOLOGICALLY WITH THE LARGE CITY HOSPITALS BECAUSE OF THE POOR REIMBURSEMENT. THERE IS ABSOLUTELY NO REASON WHY THE RURAL HOSPITALS SHOULD NOT GET REIMBURSED EXACTLY THE SAME AMOUNT FOR TREATING THE EXACT SAME DISEASES AS DO LARGE CITY HOSPITALS.

ALSO, EVERY SENIOR CITIZEN PAYS EXACTLY THE SAME AMOUNT OF PREMIUM FOR PART "B" MEDICARE WHICH ENTITLES THEM TO OUTPATIENT MEDICAL TREATMENT AND FOR REIMBURSEMENT TO THEIR PHYSICIAN FOR INPATIENT CARE. YET, ALL OF THE SENIOR CITIZENS IN SOUTH DAKOTA RECEIVE REIMBURSEMENT AT ABOUT 1/2 OF THE NATIONAL AVERAGE AND ABOUT 1/4 AS MUCH AS THOSE SENIOR CITIZENS THAT LIVE IN NEW YORK, FLORIDA, CALIFORNIA. THE NET EFFECT OF THIS IS THAT EVERY CITIZEN IN THIS STATE IS EFFECTLY SUBSIDIZING THE MEDICAL HEALTH CARE FOR ALL SENIOR CITIZENS IN THE VERY LARGE CITIES AND COASTAL STATES, AND THIS IS JUST NOT FAIR.

THIS REDUCTION IN REIMBURSEMENT FOR SENIOR CITIZENS AND THEIR HOSPITALS HAS RESULTED IN THE RURAL HEALTH CARE ACCESS PROBLEMS WE ARE NOW HAVING. THIS IS JUST NOT FAIR TO THE SENIOR CITIZENS OF THIS STATE OR FOR ALL OF RURAL AMERICA AND I BELIEVE THAT THE FEDERAL GOVERNMENT IS TREATING THESE SENIOR CITIZENS AS SECOND CLASS CITIZENS BECAUSE OF THIS POLICY THAT HAS EXISTED FOR 25 YEARS. WHILE MANY BILLS ARE BEING CONSIDERED IN CONGRESS TO EQUALIZE REIMBURSEMENT FORMULAS, MOST OF THEM WILL NOT CORRECT THE SITUATION FAST ENOUGH. I WOULD RECOMMEND IMMEDIATE REIMBURSEMENT CHANGES SO THAT HOSPITALS IN RURAL SOUTH DAKOTA ARE REIMBURSED AT THE SAME EXACT LEVEL AS OUR CITY HOSPITALS. ALSO, I WOULD RECOMMEND THAT THE "RESOURCE BASED RELATIVE VALUE STUDY" THAT HAS BEEN RECOMMENDED BY THE PHYSICIAN PAYMENT REVIEW COMMISSION BE ACCEPTED BY CONGRESS AND BE ENACTED IMMEDIATELY RATHER THAN BEING PHASED IN OVER FIVE YEARS OR MORE. AT LEAST DOING THESE TWO THINGS WILL PARTLY CORRECT THIS PROBLEM OF ACCESS.

THE SECOND LARGE PROBLEM THAT WE HAVE IN ACCESS TO HEALTH CARE IS THE UNINSURED. BEFORE WORLD WAR II IT WAS NOT UNUSUAL FOR HOSPITALS AND PHYSICIANS TO CHARGE THE VERY WEALTHY A VERY HIGH CHARGE FOR THEIR HEALTH CARE THAN THEY DID THOSE WHO COULD NOT AFFORD IT. THEREFORE, THERE WAS COST SHIFTING AT THAT TIME, AND IT MADE IT POSSIBLE TO HAVE HEALTH CARE EVEN FOR THOSE WITHOUT INSURANCE AND FOR THOSE WITHOUT THE FINANCIAL ABILITY TO PAY FOR THEIR HEALTH CARE.

NOW BECAUSE WE HAVE THIRD PARTY PAYERS, THE SITUATION IS CHANGING. PHYSICIANS, HOSPITALS AND HEALTH CARE PROVIDERS NOW CANNOT CHARGE DIFFERENT LEVELS TO DIFFERENT PATIENTS. THEREFORE, ALL PATIENTS HAVE TO BE CHARGED EXACTLY THE SAME RATE WITH THE EXCEPTION OF THE FROZEN CHARGES FOR MEDICARE PATIENTS. THEREFORE, EVERYONE NOW IS CHARGED A HIGHER PRICE. SO WHILE MOST PHYSICIANS CONTINUE TO SEE THESE 39 MILLION AMERICANS THAT CANNOT AFFORD INSURANCE, THE AMOUNT THAT WE CHARGE EVERYONE HAS TO BE HIGHER IN ORDER TO SHIFT THE COST OF TREATING THESE PATIENTS WHO DO NOT PAY FOR THEIR CARE.

THIRD PARTY PAYERS, THE FEDERAL GOVERNMENT AND ESPECIALLY BUSINESSES HAVE REALIZED THAT THIS HAS BEEN NECESSARY AND HAVE NOW REJECTED THAT METHOD OF PAYMENT. MANY THEORIES NOW EXIST ON HOW TO CARE FOR THESE PEOPLE, BUT NO ONE HAS FOUND THE MONEY TO DO IT. IT MAY BE THAT COST SHIFTING WHICH DISTRIBUTES THE COST TO EVERY SEGMENT OF AMERICA MAY STILL BE THE FAIREST WAY.

THE THIRD PROBLEM IN ACCESS TO HEALTH CARE IS RATIONING. WHETHER WE LIKE IT OR NOT, THERE HAS ALWAYS BEEN RATIONING IN HEALTH CARE. THE PRESENT SYSTEM TODAY THAT INCLUDES THIRD PARTY PAYERS USE THE PRICE TYPE OF RATIONING. INSURANCE FOR SOME PEOPLE IS SO EXPENSIVE THAT THEY SIMPLE CANNOT AFFORD THE PRICE AND THEREFORE ARE RATIONED OUT OF THE SYSTEM. THERE IS ALSO RATIONING OF PRICES BY USING DEDUCTIBLES AND CO-INSURANCE PAYMENTS BY PATIENTS. THERE IS ALSO RATIONING BY INSURANCE COMPANIES NOT ACCEPTING PATIENTS THAT HAVE A PRE-EXISTING DISEASE.

THERE IS ALSO IMPLICIT RATIONING. THE "DRG" PROGRAM FOR HOSPITALS LIMITS THE AMOUNT OF TIME THE PATIENT CAN SPEND IN THE HOSPITAL FOR A CERTAIN ILLNESS. BECAUSE OF THE SET FEE FOR THIS ILLNESS, THERE MAY BE PROCEDURES THAT COULD BE DONE AND ARE NECESSARY, BUT WHICH CANNOT BE DONE BECAUSE IF PERFORMED, IT RESULTS IN A LOSS OF PROFIT FOR THE HOSPITAL REIMBURSEMENT BASED ONLY ON THE DIAGNOSIS. DRG'S DO NOT TAKE INTO ACCOUNT THE SEVERITY OF ILLNESS AND THE COMFORT OF THE PATIENT AND OTHER HUMAN VARIABLES OF THE ILLNESS. THIS RATIONING BY THE FEDERAL GOVERNMENT IS WITHOUT CONSULTATION WITH THE PATIENT, PHYSICIAN OR THE HOSPITAL. NO RURAL PHYSICIAN OR HOSPITAL IN THIS COUNTRY CAN AFFORD THE SOMETIMES NECESSARY EXPENSIVE PROCEDURES AND EXPENSIVE TREATMENT THAT WOULD BE AVAILABLE IN LARGE CITY HOSPITALS, WHO ARE REIMBURSED 40% MORE. IN SOME CASES ONE PATIENT WITH A SEVERE ILLNESS THAT REQUIRES TREMENDOUS EXPENSES, COULD CAUSE ENOUGH PROBLEMS FOR A RURAL HOSPITAL TO CLOSE, DUE TO THE PRESENT FINANCIAL CLIMATE.

THEN THERE IS EXPLICIT RATIONING WHICH WE ARE SEEING MORE OF ALL THE TIME. THIS IS WHERE HOSPITAL AND PHYSICIANS ARE BEING TOLD WHAT TESTS CAN BE DONE, WHAT PROCEDURES CAN BE DONE AND WHAT MEDICINE CAN BE USED. OREGON HAS RECENTLY PASSED A LAW THAT LIMITS CERTAIN PROCEDURES. IT WILL LIMIT THE AGE AT WHICH CARDIAC TRANSPLANTS, BY-PASS SURGERY, HIP PROSTHESIS AND OTHER ORGAN TRANSPLANTS CAN BE PERFORMED.

EVERYONE IS UNDER THE ASSUMPTION THAT SINCE HEALTH CARE IN THIS COUNTRY CONSUMES 11.4% OF THE GROSS NATIONAL PRODUCT AND THAT IS MORE THAN ANY OTHER COUNTRY IN THE WORLD, AND THAT IS TOO MUCH. PROJECTIONS SHOW THAT BY THE YEAR 2000 THAT WE MAY BE SPENDING AS MUCH AS 14 OR 15% OF THE GROSS NATIONAL PRODUCT ON HEALTH CARE. IT MAY BE THAT EVERYONE'S ASSUMPTION IS WRONG. MAYBE WE HAVE TO SPEND MORE THAN THAT FOR HEALTH CARE. IT WILL EVENTUALLY BE UP TO THE AMERICAN PEOPLE WHETHER THEY WANT TO HAVE ACCESS TO HIGH QUALITY HEALTH CARE AT A HIGHER PRICE, OR ACCEPT LACK OF QUALITY AND LACK OF ACCESS AT A LOWER PRICE.

THERE ARE MANY OTHER PROBLEMS THAT EXIST IN OUR COUNTRY. IT IS A FACT THAT WE ALSO SPEND 15% OF OUR GROSS NATIONAL PRODUCT JUST TO FUND OUR NATIONAL DEBT. IF WE DID NOT HAVE THIS NATIONAL DEBT, WE WOULD NOT BE SITTING HERE TODAY. IF WE WOULD BE USING THE MONEY THAT WE ARE SPENDING ON OUR NATIONAL DEBT FOR HEALTH CARE, WE WOULD HAVE TWICE AS MUCH MONEY AS WE NEED TO FUND HEALTH CARE. ALSO MAYBE WE DO NOT HAVE TO CONTINUE TO SPEND 28% OF OUR GROSS NATIONAL PRODUCT FOR NATIONAL DEFENSE. THERE ARE SOME PEOPLE THAT BELIEVE THAT THIS SPENDING IS COMPLETELY OUT OF HAND. I HAVE BEEN TOLD THAT THE MONIES THAT WE WILL NEED TO DEVELOP AN ADDITIONAL AIRCRAFT CARRIER TASK FORCE, INVOLVES MORE MONEY THAN MEDICARE WOULD NEED FOR THE NEXT FIVE YEARS. SOME PEOPLE SAY THAT SIX AIRCRAFT CARRIER TASKS FORCES THAT WE ALREADY HAVE ARE TWICE AS MANY WE NEED ANYWAY.

FINALLY, IF WE ARE GOING TO CONTINUE TO HAVE COMPREHENSIVE, HIGH QUALITY HEALTH CARE, AND IF WE ARE GOING TO MAKE THIS HEALTH CARE AVAILABLE TO ALL CITIZENS IN THIS COUNTRY, THEN WE ARE GOING TO HAVE TO ACCEPT THE FACT THAT IT IS GOING TO COST MORE MONEY. WE ARE THE LAST COUNTRY IN THE WORLD TO HAVE CONTINUED FREEDOM TO CHOOSE OUR HOSPITALS, CHOOSE OUR PATIENTS, AND BE ABLE TO PRACTICE HIGH QUALITY MEDICINE. WHEN A PATIENT COMES TO ME IT IS MY RESPONSIBILITY AND MY DUTY TO DO ABSOLUTELY EVERYTHING THAT IS NECESSARY FOR THE PROPER TREATMENT AND COMFORT OF THAT PATIENT. I HAVE TO BE MY PATIENT'S ADVOCATE AND DO WHAT I THINK IS RIGHT, NO MATTER WHAT THE POLICIES ARE OF THIRD PARTY PAYERS. THE HEALTH AND WELFARE OF MY PATIENTS HAS TO BE MY FIRST CONSIDERATION AND I CANNOT LET ECONOMICS, POLITICS AND RELIGION OR ANY OTHER CIRCUMSTANCE TAKE PREFERENCE. THIS HAS BEEN THE PHILOSOPHY OF ETHICAL PHYSICIANS FROM TIME AND MEMORIAL. I HAVE TAKEN AN OATH TO UPHOLD THIS PHILOSOPHY AND I BELIEVE MOST PHYSICIANS OF THIS COUNTRY HAVE DONE LIKEWISE. IF THE FEDERAL GOVERNMENT CONTINUES THEIR PRESENT ECONOMIC PHILOSOPHY, THEN NOT ONLY WILL WE SEE MORE RATIONING OF CARE, BUT WE WILL ALSO SEE THE FURTHER DETERIORATION OF ACCESS TO AND THE QUALITY OF THAT CARE.

I WANT TO THANK YOU FOR THE OPPORTUNITY TO BRING YOU THIS INFORMATION AND IF YOU HAVE ANY QUESTIONS, WILL DO MY BEST TO ANSWER THEM.

THIS IS MY TESTIMONEY FOR THE SENATE SPECIAL COMMITTEE ON AGING FOR AUGUST 7, 1989.

RICHARD D. MULDER, MD
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Senator PRESSLER. Thank you very much. What you have said about different levels of reimbursement around the country is a major problem for us from the Midwest. The Senate Rural Health Caucus is working to eliminate the rural/urban differential. We know some of the costs are higher, on paper, in some of the big eastern cities, but the costs here are also high. In fairness, we are trying to equalize some of those reimbursement levels.

Thank you, Dr. Mulder. You have an excellent statement about those concerns. I know of your national reputation in this field, and I thank you very much for being here.

Next I will call on Dr. Stephan Schroeder, a family physician from Miller, SD. Physicians who practice in small towns are a unique group of people, because they take great responsibility.

As I understand it, they are on duty virtually 24 hours a day. If you are a small town practitioner, your patients really depend on you. So often in the bigger cities there is a group working together, and someone is on duty, and the rest are totally off, and so forth. I admire the people who provide these services.

Dr. Schroeder comes to us from Miller, and we thank you very much for being here.

STATEMENT OF STEPHAN SCHROEDER, M.D., MILLER, SD

Dr. SCHROEDER. Thank you very much, Senator Pressler.

I would like to start off by addressing two things. First of all, there is a slight correction. I am not completely in solo practice. I do have partners who have taken the time to cover my practice and allowed me to come here and speak to you today.

The second task is to publicly thank Dr. Mulder for his efforts concerning the statistics that you just heard. My profession as well as you folks owe a debt of gratitude to him. He has taken a lot of time and effort to come up with these statistics. Hopefully they will be used to your advantage in the future.

The availability and quality of health care for the elderly is a subject that is very important to physicians such as myself. An estimated 50 percent of my practice is Medicare age, so you can see that the economic viability of my practice depends greatly upon Medicare payments.

The access to health care depends on available physicians. I understand well that nurses and other allied health care personnel are certainly vital to health care delivery in our State, but I am going to restrict my comments to physicians in small communities.

The recruitment and retention of physicians into rural settings is a complex situation involving a number of factors, such as spousal satisfaction, lifestyle, availability of technology and specialty backup, and not the least of which is reimbursement.

The challenge of rural practice can be rewarding both spiritually and financially. Only recently, the increasing frustration with the "business" of medicine may take its toll on those presently practicing and prospective practitioners in rural communities.

The spiraling costs of health care and the budgetary restrictions of the Medicare system are of concern to all of us, especially physicians. However, the continual effort to limit physician reimburse-

ment may eventually result in limited elderly access to health care.

The well-documented geographic disparity mentioned by Dr. Mulder will no doubt entice physicians to more urban practices. It seems inevitable that an overhaul of the present system is necessary and that present expenditure growth really cannot be tolerated.

In addition to payment inequality, rural physicians face other obstacles which I would like to discuss. One of these is what I term a bureaucratic nightmare of "medically unnecessary" letters. This is correspondence we receive from Medicare carriers that denies payment for certain services that may have been rendered to patients. For instance, if visits are scheduled too frequently, or patients request to be seen too often, payment can be denied for reasons that we, as physicians, have really never seen written down. It's quite a complex and confusing situation that I have yet to understand. But it certainly is a frustrating situation to receive correspondence like that.

Even more alarming to me is the difficulty encountered in obtaining Medicare payment for critical care services which are often rendered at inopportune times to extremely ill individuals. It often requires repeated correspondence to obtain payment for services that are probably a fraction of that which are billed.

As an example, my partner recently received a Medicare payment of $63 for 2½ hours of acute care rendered at 2 a.m. to a heart attack victim. Certainly a persistent refusal to reimburse legitimate care is going to lead to fewer physicians who are willing to take on such responsibility. When compared to the charges of other professionals, physicians' fees really cannot be deemed excessive, in light of what has gone on there.

In addition to reimbursement problems, I would like to make a comment about the efforts of the peer review organizations. These are organizations that are contracting with the Government to oversee the quality and costs of Medicare care that is being delivered. The problem that it gives to physicians has become quite a dilemma.

Peer review organizations give physicians the responsibility of making the correct diagnosis at the correct time for patients that—at the present time it includes only hospital care—but basically, if a patient is deemed not ill enough for admission, or judged to be too sick at the time of discharge, the physician is reviewed by the peer review organization and left liable for possible sanction if wrongdoing is found.

The problem that we have run into is how does one appease anxious relatives who want their loved one, grandmother, aunt, whatever the case may be, admitted with what may be necessarily minimal symptoms?

On the other hand, how do we appease anxious hospital administrators, such as Mr. Huss, down at the end, who see huge DRG losses when someone with a severe illness is hospitalized for a great length of time?

I am not against PRO's, in fact I am vice president of the board of directors for the State PRO, so don't get me wrong. I am only

bringing them up as an example to show the difficulties that physicians encounter in dealing with the Medicare system.

As far as solutions to the problem, I think first and foremost, our elderly need to be informed and educated about the fact that health care is expensive and funds are limited. They need to understand that expenditure targets, DRG's, and "medically unnecessary" letters are all forms of health care rationing, however you cut it.

These items may well be needed to limit our growing expenditures, but recipients need to realize that they cannot expect limitless, high-technology care, and that Medicare won't pay for all of it. Patients must know that options such as home health care, swingbeds, and nursing home convalescence are alternative solutions to prolonged in-patient care. By the same token, organized medicine and Government bear the burden of delivering this message to our elderly.

Once patients and their families understand the financial situation of the Medicare system, I think we will all be better equipped to deal with the grim realities of economics and medicine. The idea that Medicare is the sole source of health care coverage for the elderly is probably erroneous, and needs correction.

Other solutions may lie in the implementation of a resource-based physician reimbursement system, one that does not have geographic disparity. Certainly safeguards need to be included in the system, so that excessive-balance billing by physicians is eliminated. By the same token we need to avoid inflexible expenditure targeting by the Government, especially in the areas of primary care.

Protection also needs to be afforded to needed rural hospitals by, again, emphasizing equitable reimbursement. These facilities would benefit perhaps by helping transform them into comprehensive health centers that are concerned with more than just in-patient care. I think you will hear more on that from Mr. Huss.

Specifically, rural clinics may be helped by legislation such as that of Public Law 95-210, which is known as the Rural Health Clinic Act. This is a system where health care recipients' care is reimbursed on a cost basis, rather than on a usual fee-for-service basis, and the experience thus far with clinics that employ physicians' assistants has been somewhat favorable, and the expansion of this idea may help rural health care.

Medicare's attempt to save physician payment has focused on such items as frozen fees, maximum allowable charges, and into forcing the acceptance of assignment. This, coupled with the inequitable payments, has reduced income to many physicians in rural areas. At the same time, needed practice items have not decreased or frozen their costs to any extent. Medical goods, malpractice insurance, diagnostic equipment, and pharmaceuticals have all increased prices dramatically.

A physician is prohibited from raising office fees to Medicare patients at the present time. However, at the same time, we are paying individuals such as X-ray machine repairmen fees of $100 per hour, plus costs and mileage, etc., for items that we have no control over.

Rural health and elderly access to health care are presently popular topics for discussion. Unfortunately, it is going to take more

than talk to reverse the present trend and make family medicine in rural communities a popular choice. Presently, South Dakota could place 30 to 40 family physicians, and likely that many more in another 5 years. A supreme effort will be needed to accomplish that goal.

Continued governmental support for primary residencies and scholarships and loans for health care delivery in rural areas is essential.

I realize that health care reform is going to be a bitter medicine for individuals to swallow. I hope my comments will not be construed as those of a greedy, self-centered physician. I enjoy geriatric medicine, and never have nor will refuse to care for the elderly for any reason. Yet I fear the future because of our general trend. Hopefully our system and its patients can adjust to the change, and keep rural medicine dependent practices well-staffed and functioning in the future.

Thank you.

Senator PRESSLER. Thank you very much, Dr. Schroeder. Your testimony represents the grassroots practitioner in rural America.

Next I will call upon Gerald Huss, a Hospital Administrator at Faulk County Memorial Hospital in Faulkton, SD. The hospital is a small rural facility that provides health care for many older persons in that community, and people of all ages.

STATEMENT OF GERALD HUSS, HOSPITAL ADMINISTRATOR, FAULK COUNTY MEMORIAL HOSPITAL, FAULKTON, SD

Mr. HUSS. Thank you, Senator Pressler, for this opportunity to testify before the hearing from a small hospital's perspective.

Ladies and gentlemen, when a rural hospital closes, the physician leaves. Nurses and other health professionals seek employment outside of the community, or are also forced to leave. Within a short time access to health care could be a big problem, and the people could be forced to drive many miles to seek routine health care, not to mention emergency care.

Limited access to health care affects everyone negatively. But who does it impact the most? The elderly and the poor, those who need it and use it the most, those who don't drive, those who can't afford an automobile, those who find it difficult to travel, those who must rely on others, and those, for some of the aforementioned reasons, simply put off seeking routine health care until they have a major health problem.

Hospitals not only provide the health care necessary for quality life in rural America, but also contribute a great deal to the economic survival of the community they are located in. The hospital is one of the largest employers, and one of the biggest industries in their community. Total annual expenditures of all hospitals in South Dakota is over $370 million. They employ some 11,000 full- and part-time personnel, and are the second leading employer in the State.

Hospitals should be viewed not only for their contribution toward health care and quality life, but also from an economic development viewpoint.

The paramount problem is to not let hospitals close in a haphazard manner, but to identify and ensure the continuation of all strategically located rural hospitals, and have a planned transition for those other hospitals that may close. If any rural hospitals must close, there should be an orderly and well-planned transition to an alternative that would ensure that the professional, technical, and transportation components of health care will remain within that community which will guarantee access to primary health care.

In an effort to maintain access to rural health care, legislators must not only introduce and sponsor, but must champion legislation that would mandate that the Federal Government establish and provide for the following: eliminate the urban/rural payment differential; an optional cost-based reimbursement system for rural hospitals of 50 beds or less; a hardship fund for hospitals of 50 beds or less who are essential to their community and who have a high percentage of Medicare admissions, lose a physician or have a negative operating margin from Medicare patients; ensure adequate payment for outpatient medical services; expand the National Health Service Corps and increase Federal subsidies for physician extenders and nursing education; give additional special consideration and financial assistance to those who qualify as sole community provider hospitals; identify and ensure continuation of all strategically located rural hospitals; and define and ensure an orderly and well-planned transition for those other hospitals that may close.

It is an uphill battle for rural hospitals of 50 beds or less because the Medicare reimbursement system is simply not fair, and will result in many hospitals of this size closing. When a hospital closes, it strangles the economic life out of the community. It negatively impacts upon the quality of life, and ultimately inflicts fear and despair into the lives of those who remain.

All too many small and rural hospitals have already closed, and many more are in a critical stage and very near closing. Action must be taken to ensure that all strategically located rural hospitals continue to be open to provide quality health care and to ensure that the people who choose to live in rural America have access to a hospital, and are not forced to drive by a closed hospital to seek health care.

Senator PRESSLER. Thank you. That was one of the most precise presentations I have ever heard. I am working with my colleagues in South Dakota and other rural States on several of the items that you focused on, hardship funds for hospitals with 50 beds or less, the concept of an optional cost-based reimbursement system for rural hospitals of 50 beds or less. There are a number of things, such as your recommendation to expand the National Health Service Corps, to increase the Federal subsidy for physician and nursing education—that we will have to face up to. I think that your eight specific, concise recommendations are very, very useful, and I will certainly carry them back to the committee.

Next I am going to call on Ray Hopponen, the former Dean of the College of Pharmacy at South Dakota State University. He is a pharmacist. Recently, the Senate Aging Committee held a hearing on the price of prescription drugs.

I have read Ray's prepared statement and it is excellent. I am really pleased that he travelled all the way from Burke to be here today to share some of his views with us.

STATEMENT OF RAY HOPPONEN, PHARMACIST

Mr. HOPPONEN. Thank you, Senator Pressler.

Ladies and gentlemen, I would like to give you a little background of my own, first, so that you will understand where I am coming from.

I retired from the Deanship of the College of Pharmacy 3 years ago, and since that time I have been practicing as a relief pharmacist. This is a pharmacist who comes in and spends 1 day or a couple of days a week in the pharmacy so that the regular pharmacist has some time off, and fills in during vacations, also.

During these 3 years, I have worked in five different pharmacies, so I have had expe.ience in seeing what goes on in more than one pharmacy. On the basis of that experience, I have become increasingly irritated with the way that prescription drug costs to the pharmacist have continued to escalate over the past several years.

This is a major concern to many South Dakota pharmacists, because we are the ones that have to face the consumer when the prescription price is increased, or when the price seems outlandishly high.

The Bureau of Labor Statistics show that the costs to the pharmacists during 1988 went up by 8 percent. In the preceding 3 years, they increased from 9 to 10 percent each year and prior to that, the increase was in the double digits. Now, this is more than twice the inflation rate of 4.5 percent. So there is something wrong there.

Prescription drug prices for early 1989 were up by 6.9 percent over the same period last year, and 17 major drug costs rose by an average of 8.9 percent. So again, we are exceeding the inflation rate in the way that the costs to the pharmacist of prescription drugs are going up.

The Lilly Digest is an analysis that is made of drug store operating statements each year by the Eli Lilly Co. Pharmacists send in their operating statements and about 1,500 to 2,000 pharmacists do this each year. The company analyzes them to see how their operations are going and how they compare with what happened the previous year. During 1988 pharmacy sales of these drug stores went up by 12.1 percent. However, the gross margins dropped by about one-half percent in 1988.

The cost of goods that pharmacists pay for increased by 13 percent. So you can see that there is a squeeze between his costs and his profits going on. His profits held steady at 3.3 percent, which is the same as it was in previous years, in spite of the fact that sales were up by 12.1 percent.

The decay in gross margins has been going on for 15 years. That indicates that the manufacturers' cost increases are not being passed on completely to the consumer, but the pharmacist is absorbing part of those increases. In October 1988, I started keeping track for myself of price increases in one of the stores that I worked in, because I was checking in drugs and placing them on

the shelf, and I was noting these prices differences in the cost to us.

During this time, up until this past week, I recorded 121 price changes. Three of those were decreases of 4, 4, and 19 percent, respectively. The other 118 were increases that ranged from 4 percent to 48 percent, for an average of 11.95 percent. So the pharmacist was paying that much more for the prescription drugs that he uses to fill your prescriptions. Six of those drugs increased twice in 1 year.

One South Dakota pharmacist that I talked to dug out his computer records and showed me that his prescription prices increased by $1 per year in the last 4 years. His prices went up from $13 plus to $17 plus. But his percentage of increase went down from 7.6 to 7.1, to 6.6 to 6.25 percent, showing that he was absorbing part of this cost that the manufacturer was charging him.

My own experience here is that when we get a cost increase, we tend to pass on to the patient the dollar increase only. We don't increase the percentage. Consequently, the amount that the pharmacist gets as a percentage of that prescription slowly shrinks.

A major concern of pharmacists—and I have spoken to a number of them about this, is one we believe is contributing to this increase in drug costs to the pharmacists—is what is termed differential pricing. This is a system that is followed by most of the pharmaceutical manufacturers in the United States. That is, they will charge different prices to different groups.

For example, a hospital will get a different price than a Main Street pharmacist. An HMO, or a doctor's clinic will get a different price than the pharmacy on Main Street gets. These prices are usually less than what the pharmacist pays. In fact, some mail order pharmacies can fill prescriptions for less than what it costs the Main Street pharmacist to buy that drug for use in his pharmacy.

Another thing that is creating some problems regarding mail order pharmacy is that patients will, because it is a long way away from the pharmacy that they deal with—in some cases it's 30 or 40 miles in our area since we serve a number of small towns in northwestern Nebraska—and in order to save money on their prescriptions they will use mail order pharmacies.

There is a problem there in that the service is not always the best, and patients sometimes forget to order soon enough and they run out. I have had on several occasions patients come to me with containers from mail order pharmacies asking that I provide them with some drug to carry them over until they can get their prescriptions from the mail order pharmacy.

These mail order pharmacies are a big problem in that the patient does not get as good service as he does from his local pharmacy. He doesn't get to talk to the pharmacist. The pharmacist does not get a chance to oversee the medications and check to make sure for example that he is getting his blood checked by the physician if he is taking coumadin, which is a blood thinner, or that he continues to take his medication regularly, or that he is not changing the dosage. This is impossible from the mail order pharmacy. That's a bit of a problem, I think, of health care in general.

I have noticed one other thing that is a bit of a problem, that is probably attributable to the patient's conception that prescription

prices are high. I personally feel that they are high, higher than they should be. There is a growing tendency among older patients on chronic care medications to try to cut down on the costs.

They do this in three ways. One is that they may extend the dosage schedule. Instead of taking one tablet a day, they will take one every other day, trying to stretch out their prescriptions, so that they can save a little money. Or, they will use one-half a tablet instead of a whole tablet when the directions call for one. Or, they may use it only when they feel that they need to. This is especially bad, because many medications that are used for chronic illnesses must be taken on a regular basis.

The evidence I have for this sort of thing happening is that the time period is extended between refills. Instead of getting a prescription every 30 days when the patient should be using one tablet a day, it might be 60 or 70 or 80 days before they get it refilled again, indicating that they are not taking their medication the way they should. Sometimes it is evidenced by the patient asking for only half the number of tablets that they should be getting.

In general, I think that the level of pharmacy services being provided in South Dakota is quite good. I am quite pleased with the drug distribution system that we have. We can get drugs from a wholesaler in 1 or 2 days, so that there is no place in the State that does not have access to all pharmaceuticals.

But these continually escalating acquisition costs that the pharmacist has to pay are creating a real price squeeze on the rural pharmacist, whose own margins are being squeezed and it is becoming more and more difficult for him to stay in practice.

The loss of any rural pharmacy will lead to a significant loss to a community. Not only has there been a loss of a source of prescription drugs, and over-the-counter medications, but there is the loss of an individual who is able to provide advice and information to the community at large and we do provide a lot of that advice to people who come in and ask about their prescription drugs, or ask about over-the-counter drugs or other medications.

Thank you.

Senator PRESSLER. Thank you very much, Ray. I think your two-page statement is an excellent summary of the issues of prescription drugs costs. In fact, one thing that I learned—and I'm never ashamed to say that I learn something new every day in these hearings, that's what they're for—is that some health insurance plans require employees to utilize mail order pharmacies for long-term medications. I did not know that about this arrangement and would like to learn more about it.

I think this is one reason why field hearings are good—they get us out of Washington. We learn about other issues that affect the delivery of services and the lives of people. I thank you very much.

Next I call on Wayne Muth. Wayne is vice president of long-term care for the Presentation Health System. Wayne provides guidance to Brady Memorial Nursing Home in Mitchell, Mother Joseph Manor in Aberdeen, and Prince of Peace Retirement Center in Sioux Falls.

STATEMENT OF WAYNE MUTH, VICE PRESIDENT OF LONG-TERM CARE FOR PRESENTATION HEALTH SYSTEMS

Mr. MUTH. Senator Pressler, I want to express my appreciation to you for bringing this type of hearing to our State. Many of us would not have this opportunity if we were not located right here.

The long-term care facilities that are operated by the Presentation Health System offer a wide range of service to the elderly. I want to concentrate my remarks on those services that deal with the in-patient nursing care. I took a quick count here, and this may not be accurate, but I would say we have about 160 or 170 people in the room. Do we have anyone here that is a resident of a nursing home?

I will refer to that a little bit later. The people that are residents of nursing homes are called many things, the "frail elderly," the "old old," the "ill elderly." Whatever title we may use to identify them, I think we need to understand that there are several characteristics of this group.

They are both old and in poor health. The average age of the individuals in our nursing homes is 86. Their care requirements have increased as they have been discharged earlier from hospitals, one of the results of DRG, which was mentioned by one of the earlier speakers.

They have a wide range of physical ailments. Many of them, a very high percentage, also suffer from Alzheimer's disease, or related dementia. They are definitely a minority group, representing a small percentage of the elderly population, less than 5 percent of those over the age of 65.

Most of us will never use the services of an in-patient nursing home, but I believe we have the responsibility to provide for those who will. I believe that the laws and public policy that exist are passed primarily for the weak, and the politically weak, especially. I think our society has always tried to protect the rights of minority groups. We have not always succeeded, but I think the advocacy has always been there.

I believe the frail and elderly nursing home patients represent the most oppressed minority group in our society today. They have no effective advocate. They are not represented at this very important hearing today, and if my count is correct, we should have at least eight nursing home residents with us today to represent that portion of the population over 65.

As an administrator in long-term care, I am involved in many things. I have been an administrator for 23 years. The environment has changed. It has intensified in many areas. I have found in my work an environment that has been weighted down with surveys, reports, documentation, deficiencies, plans of correction, and so forth and so on.

I have also found frail, oppressed, and rejected people. I have found loving relationships. I have found confused and frustrated families, mistrust between providers and regulators, and national policy that sometimes seems to want the provider and the regulators to be adversaries.

I have found staff who feel overworked, underpaid, and many times unappreciated by society. I believe in many ways, they too have become an oppressed minority group in our society.

We are honestly trying to develop public policy to make us all feel better about the aging process. We think that is one of the reasons that we have OBRA 1987—the Omnibus Budget Reconciliation Act of 1987—which is nursing home reform.

I am going to try to place some things on the table today that perhaps would not get there if I were not here. We need to make some basic directional changes very soon. I think we definitely have a crisis in in-patient long-term care today because our direction is off the mark, and also because our resources are not limitless. We have heard that already this afternoon, too.

We hear basically two things in our public policy direction today, quality must be improved—OBRA—and the Federal deficit precludes infusion of resources. I think we are in "fix-it" mode regarding nursing home reform. I don't know if we will be able to, or whether we are going to be willing to pay for fixing it, and if we are not, it will not be fixed.

Sanctions are provided and can be applied, deficiencies can be issued, facilities can be decertified, but those actions will not fix the situation. I think we all like to fix whatever might be hurting us. That's our nature—that's our society's human nature. I think one of the things that we are trying to do through public policy is to also help us fix our feeling about the aging process. Unfortunately, Senator Pressler and all the other people in Washington cannot fix many aspects of the aging process. We need, as a society, to start to cross over into accepting some of the realities of aging and of death, and I think public policy needs to help us do that.

A message that public policy does send us and one that is heard very well, especially by the people working in nursing homes, is that the poor elderly are not worth very much. That message is heard very loud and clear by the people working closest to the residents, those that provide the most hands-on care, the nursing assistants, housekeepers, dietary aides, etc.

Our public policy says to them that their work is not worth much, minimum wage, or slightly higher is what their worth is, and our public policy can't even determine what that minimum wage should be. The public policy says "not worth much" but I think our public and you and I expect a great deal. We expect high quality, but in many ways we don't want to pay for it.

Much has been said about access, and I would like to concentrate a little bit on that. Public policy has established layers of activities to help the poor and elderly. One of those layers is preadmission assessments that have been created to help people make the correct decision, and hopefully keep them out of the nursing home.

What it does in many ways is to make the obvious decision for that family, for that home unit, that much harder to make, and in the process increases the cost to society. In many ways the process disregards the family physician, and it substitutes Government bureaucracy.

Access to good health care is something that is important to all of us, but in many ways our public policy throws roadblocks in front of some very hurting people. Public policy says that we will

mandate quality and maintain budget neutrality. I think that's the message that I hear most often, and unfortunately many of us have started to believe that message. We can have quality, but we must be ready and willing to pay for it.

I think we must come to understand that our human resources are disappearing fast in a State like South Dakota. Do we really think that we can continue to convince enough people to work in our facility at a job that is very difficult, many times unappreciated, full of frustration, and then to do so at a wage below what others receive?

The reality is that we should not and cannot expect that. They won't continue to do this very important job, they won't continue to shoulder the burdens of our society. And we shouldn't expect them to.

Affordable nursing home care is something we all want, and one of the items that we wanted to talk about today. Usually, this might mean that what we have now is not affordable. I understand the concerns of people when it comes to the cost of nursing home care. I want to put another message out in front of us today, though, the fact that what we have for skilled, in-patient nursing care may be considered a bargain in our society, rather than too costly, too expensive, not affordable.

The highest Medicaid rate in South Dakota as of July 1 for a free-standing nursing facility was $51.79 per day. That is the most any facility could expect from the Medicaid program for total care for some very dependent people, people who cannot do many of the things that you and I take for granted every day, that has to be done by somebody else. The staff of that nursing home is that somebody else.

Private rates range anywhere from $30 to $70 a day, depending on the amount of care, and the services that are delivered. Now what do you compare that with? It's rather difficult, but I know that there are many expenses that you and I have. Most of us have stayed in a motel, we know what that costs, we have eaten in restaurants, we know what those costs are. Some of us go to a laundromat once in a while to do our laundry, we know what those costs are, we may hire someone to do yard work, we may even have a housekeeper come in.

We probably have never hired an R.N. to come in, we haven't hired a dietitian or a therapist, or someone working in pastoral care, a social worker or a lot of other things that are provided for in those per-day costs in a nursing home. When we start adding all these costs up, I am convinced—and I am through being defensive or apologetic about the daily costs of a nursing home—I truly believe that our society needs to start to recognize that.

Nursing home care may not be affordable for each individual, and I certainly understand that. I do believe that it is the affordable solution for many of our society's problems, that we through our public policy debate and decisions, need to find those ways that we can best do that.

I would like to list some things that I think need to be considered as we develop that public policy. I think we need to utilize case mix reimbursement to assure adequate payment for services required by the "frail elderly." Remember that definition of a frail elderly

person, that's what I am talking about here. I am not talking about the vast majority of those of us that are at or near 65.

We need to fully recognize the cost impact of regulations and provide the resources to pay for them, or else relax the regulations. We need to acknowledge that in-patient nursing care is the appropriate cost-effective service program for the frail elderly. We need to recognize the importance of the family physician and other health care provider professionals, and encourage their participation in serving the frail elderly.

We need to assist families and other decisionmakers in utilizing the resources available. We need to recognize and reward the important work accomplished by the nursing home staff. We need to help society deal with the reality of the aging process, and we need to foster a better understanding and respect between providers of services and Government and consumer groups. We need more than simply adding more regulations to the nursing home industry, which is already the most heavily regulated part of our society.

It won't be easy. I think a lot of the people that need to help in that process are in this room, including our own Senator Pressler, and I am happy to be here.

Senator PRESSLER. Thank you very much, Wayne.

We next call on Gail Ferris. Before calling on her a couple of people asked me about notch. So let me say what we are going to do about it. We have been struggling. My mother from Humboldt, SD, is a notch baby. We have co-sponsored legislation to resolve the notch problem. It has not moved through the Finance Committee. There is a very strong feeling that the agreement of 1977 should remain as is to protect the fiscal integrity of the Social Security Trust Fund. Since that Trust Fund has a surplus, Senator Sanford and I have sponsored a bill to give the notch babies some adjustment. We think we are going to be able to pass that, although I will not promise anything. We are struggling with it.

There is great resistance to do anything that would open up the 1977 amendments that were agreed upon. But I want to say that I am well aware of notch, that I hear about it all the time, and I am co-sponsoring legislation to correct the notch problem. In fact, some people have criticized me for sponsoring the compromise bill.

Gail Ferris is the Director of the State Program on Adult and Aging Services. Gail directs programs throughout the State that assist seniors in living a quality life. She is one of our last three speakers. If they can each give us about 5 minutes of substance and then we will go into questions and answers.

STATEMENT OF GAIL FERRIS, DIRECTOR OF STATE PROGRAM ON ADULT SERVICES AND AGING, SOUTH DAKOTA

Ms. FERRIS. Thank you, Senator Pressler.

The Office of Adult Services and Aging is the same agency that is responsible for administering the Older American program and other programs that are intended to serve the elderly throughout the State. We appreciate this opportunity to provide testimony here since we have an obligation to be an effective and visible advocate for older South Dakotans.

I would like to give you just a little bit of background about the Office of Adult Services and Aging. We are a part of the Department of Social Services. We provide services to persons over the age of 60 through a couple of different networks.

One of those is a network of social workers. Many of you may know the social workers here in the Aberdeen area. Statewide we have about 60 social workers who provide services in case management, we have a network of homemakers that are also providing services. We have homemaker supervisors, and we have homemakers, we have people out there who are providing services in respite care, and adult foster care, and then over here—that's just very brief, but over on the other side we have a network of grantees who, through Older Americans Act moneys, provide nutritional programs for the elderly, transportation services, adult day care, we do a little bit of senior center renovation. So that gives you just a very brief picture of what we do within the Office of Adult Services and Aging.

Our group is here today to provide testimony about issues of long-term care. We are taking a wide-angle approach to the total needs of the elderly in terms of alternative services and access to those services. Now, in order to get a good picture of the total needs of the elderly, I would like for you to envision in your mind a continuum, think of long-term care as a continuum, beginning at one end is independence, and moving along to the other end, dependence, or institutionalization.

Out of necessity in South Dakota, the scarce resources that we have are targeted primarily to serve those at the most dependent extreme of the continuum, and that is the frail and vulnerable, the institutionalized elderly. Once individuals reach this point, this dependent-most point, they need a very intensive and very expensive level of care.

Over 50 percent of those residing in nursing homes in South Dakota must rely on Government funds to provide their care. This is not only burdensome for an already debt-ridden society, but it strips elderly people of more than their resources, it strips them of their dignity.

Early intervention is critical at this end of the continuum. Early intervention is critical in order to slow down their progression along this continuum of need. Early intervention can delay deterioration of one's mental or physical condition to the point of requiring institutional care.

Early intervention begins at the opposite end of the continuum with education and participation in preventive programs and supportive services. Let's take a look at an ideal continuum of care.

Some of these kinds of services we have in South Dakota, and others we do not. But if we start down here at this end of the continuum we look at things that are available for older people who are still very independent. There are educational programs for patients and family members to provide education on health and social problems, and among those is retirement planning.

We have started to do some retirement planning seminars and are working with AARP and through other community organizations. Also, at this end of the continuum are wellness programs, exercise programs, smoking cessation, all those kinds of things to

help keep people well. There are recreation and socialization things that happen at senior centers.

Independently, older people embark on travel. There are also humanities. We have a program in our office called Senior Olympics. I understand that there was the first Senior Olympics here in Aberdeen just a week or so ago, one of the hottest days of the year, I believe. We have a Statewide Senior Olympics that is the first week of September.

There are also continuing education programs, things like elderhostels, senior volunteer programs. Aberdeen has a very active RSVP program to keep people involved in their communities.

Moving along this continuum, then, from total independence to where you have a certain amount of needs here, there are certain things available in the community. Things like housing, where older people can live together in a congregate living facility, for example, where a certain number of services may be available, maybe a meals program, or a transportation program, or a nurse who comes in from time to time, or a system of an emergency response, with call lights in their rooms, or whatever. Those kinds of things are available through housing.

There are adult foster homes, there are all kinds of shared living arrangements. Here again, I am talking about an ideal—these things may or may not yet exist in South Dakota.

Moving further along the continuum then, there are outreach and linkage kinds of services with health screening, blood pressure screening, cholesterol testing, those kinds of things take place in senior centers.

There is transportation. I would like to digress just for a moment and talk in a little more detail about transportation services for the elderly in South Dakota. One of the things that we use Older Americans' money for in this State is transportation for the elderly. Now, we have used all of the money that we have available for this particular purpose. We have no way that we can expand right now.

We have services in about 24 different projects statewide, and based in about 190 different communities throughout the State. That may mean that they get services every day of the week, or in some communities, they may get services once a month. We feel like we have coordinated very well with the Department of Transportation. They have a certain pot of money that they use for this thing as well.

We try to maximize resources by combining our funds. We use money from our office to match the money from the Department of Transportation. We have worked together in purchasing vehicles. We have coordinated together in purchasing vehicles. We have coordinated things from an administrative standpoint to where we do joint training sessions for drivers and managers, we do joint applications, joint assessments, and in some cases we have done joint audits of these particular programs, so we feel like we have coordinated as much as we can with these two particular resources to maximum services available to the elderly.

It seems though, there is only one way to get more transportation services for the elderly, to either expand services to more communities, or to make services available more frequently, and that

is, we need more money. We feel like we have reached the maximum with what we have available there in transportation.

Other community resources that are available are the congregate meals program. There are support groups, I mentioned adult day care, and in-home services. We move on along the continuum to in-home services where we have home-delivered meals, we have things like friendly visitor programs, telephone reassurance programs, and the homemaker program that I mentioned just briefly. There is personal care, emergency response systems, respite care, home health, and hospice care.

When we get further down here to the end we have institutional care. We have supervised personal care, intermediate care facilities, skilled nursing facilities, and hospitals.

Now in an ideal system of long-term care, care starts early. The system should help prepare older persons and their families for what lies ahead and link them to services that will help maintain independence.

As I mentioned earlier, the amount of financing for institutional care versus alternative care is highly disproportionate. In South Dakota, the ratio of dollars available is approximately 1 to 6—alternative versus institutional care. In South Dakota about 8 percent of those over the age of 60 reside in nursing homes. As one lives longer, of course, the chances of one day living in a nursing home climb to approximately 33 percent of those over age 85.

In order to balance the resources allocated to institutions versus alternatives and slow the growth of numbers entering nursing homes prematurely, South Dakota instituted a preadmission assessment process last July 1, 1988. The purpose of this assessment is to inform the elderly and their families of community services and the alternatives that are available, and of other options and help them to determine the appropriateness of institutional care.

In order to implement this whole big picture of long-term care, which involves skyrocketing health care costs, and as we know, a booming elderly population, more dollars must be earmarked for preventive and alternative services.

Thank You.

[The prepared statement of Ms. Ferris follows:]

WRITTEN TESTIMONY
by
Gail Ferris, Program Administrator
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The Office of Adult Services and Aging is the state agency in South Dakota responsible for the administration of Older Americans Act programs in our state. We appreciate the opportunity to provide testimony at this public hearing since we have an obligation to be an effective and visible advocate for older South Dakotans.

Our purpose today is to provide some testimony regarding issues in long term care, but taking a "wide angle" approach, looking more at total needs of the elderly in terms of alternatives and access to those services. In order to get a good picture of the total needs of older people, we need to look at the system of long term care as a continuum ranging from independence to total dependence.

Out of necessity, scarce resources are targeted primarily to serve those at the dependent - most extreme of the continuum - the frail and vulnerable, and the institutionalized elderly. Once individuals reach this point in the system, they need a very intense level of care - - and a very expensive level of care. Over 50% of those residing in nursing homes in South Dakota must rely on government funds to provide their care. This is not only burdensome for an already debt ridden society, but it strips older people of more than their resources - - their dignity as well.

Early intervention is critical in order to slow down the progression along the continuum of need. Early intervention can delay deterioration of one's mental or physical condition to the point of requiring institutional care. Early intervention begins at the opposite end of the continuum, long before there is a crisis with education and participation in preventive programs and supportive services.

Let's look at an ideal continuum of care and the various levels of programs and services that appear along that continuum.

Independence

. Educational programs for patients, families and community members to provide information on health or social problems. Retirement planning courses.

. Wellness programs - exercise programs, smoking cessation, weight reduction programs, nutrition education, health maintenance, stress management.

. Recreation/Socialization - activities at senior centers, travel, arts and humanities programs, Senior Olympics, continuing education (elderhostels).

. Volunteer Programs - recruit and involve older people to remain active, contributing members of the community.

The following will delineate a wide variety of resources and supportive services that, when available, provide continuous care as health conditions decline and needs increase:

Community Resources

Housing

. Continuing Care Retirement Communities

. Senior Housing

. Congregate Care Facilities

. Adult Foster Homes

. Shared Living Arrangements

Outreach and Linkage

. Health Screening e.g. blood pressure, cholesterol testing.

Information and Referral - may be done through senior centers, Social Services.

. Transportation

Congregate Meals - fosters socialization, nutritious meals, happier, healthier lifestyles.

Support Groups - education and support for victims of disease and/or their families and their caregivers.

Adult Day Care

. Social models concentrate on socialization and supervision.

. Medical models provide care for those with more severe physical impairment.

In-Home Services

. Home delivered meals

. Friendly Visitor programs provide companionship to those who are homebound.

. Telephone Reassurance - provides a checkup, monitoring service.

. Homemaker Services

. Personal Care

. Emergency Response Systems

. Respite Care

. Home Health - nursing/medical care, therapy

. Hospice

Institutional Care

. Supervised Personal Care

. Intermediate Care Facilities

. Skilled Nursing Facilities

. Hospitals

In an ideal system of long term care, care starts early. The system should help prepare older persons and their families for what lies ahead and link them to services that will help maintain independence.

As mentioned earlier the amount of financing for institutional care vs. alternative services is highly disproportionate. The ratio of dollars available is approximately ___ ___ ____.

In order to impact the ill picture of the future - - skyrocketing health care costs and an aging population - - more dollars must be earmarked for preventative and alternative services.

In South Dakota, about 8% of those over the age of 60 reside in nursing homes. As one lives longer, of course the chances of one day living in a nursing home climb to approximately 33% of those over 85.

For those who wish to plan wisely their financial future and make provisions for the day they may have to live in a nursing home, there is the availability of long term care insurance.

A short time ago, Congress passed the Medicare Catastrophic Coverage Act of 1988. This Act improved the package of services under Medicare, but created a further awareness that nursing home expenses represent catastrophic costs to many elderly. During the past several years, states have often felt that private insurance companies could ease the expense of nursing home stays.

At the state level, much has been accomplished to promote and develop private resources to assist in payments for nursing home care. In April of 1986, Governor Janklow issued Executive Order 86-05 establishing a multi disciplinary task force on long term care. This task force issued a report recommending the development of minimum standards for long term care insurance. This task force goal was realized in 1989 and now we have a complete chapter of the South DSainta code exclusively addressing long-term care insurance. Currently, the South Dakota Division of Insurance is working on a package of administrative rules to implement the new law.

With this progress, it is somewhat alarming to note efforts at the federal level to establish federal standards for long term care insurance policies. In most instances, where federal model standards are developed there is an expectation that states will conform to the federal requirements.

With the enactment of SDCL 58-17B, South Dakota recognizes the need to balance consumer and industry interests. We believe that states are in the best position to determine the nature and scope of this balance.

What is needed is an emphasis on education rather than intense regulation. A recent study by the Health Care Education Associates determined that there is a general lack of knowledge about long term care insurance. According to the study, 50% of hospital social workers either overestimated or underestimated the risk of needing long term care. About 75% overestimated or underestimated the annual cost of nursing home care. Nearly 20% incorrectly believed that long term care costs are fully paid by Medicare or Medicaid. Most have difficulty with questions dealing with the scope, cost and benefits of long term care insurance policies.

If hospital social workers are unable to correctly respond to questions about long term care, we can assume that many elderly are confused about the nature and intent of nursing home insurance.

Senator PRESSLER. Thank you very much, Gail. Both you and Wayne raised excellent points on nursing homes. I always tell people that even if you don't have a relative in a nursing home, we ought to have an interest in them, because we might end up in one some day, and it is something that we should think about.

Next we have Peg Lamont, who is very active in our State. Peg Lamont, a resident of Aberdeen, is one of my best friends and a former State legislator. She is well known for her work in the field of aging. In June of this year the National Association of State Units on Aging awarded Peg Lamont the Louise Gerrard Award for her work with rural elderly. In addition, Peg is a member of the Federal Council on Aging. The Council advises the President and Congress on the needs of the aged. I know she was a member of the White House Conference on Aging, probably no South Dakotan has done more work and continues to do more work with the elderly. She is also a person that I call when some of these bills come up.

Peg, we'd like to hear from you.

She went to the airport? She will be back, how about that?

Then we will call on Lucille Stafford. Lucille is from Ipswich, SD. She was my senior intern this summer. You haven't gone to the airport, have you, Lucille? Where are you? Right there. There you are, yes indeed.

Lucille comes here with a sense of community pride. Every year since I have been in the Congress and the Senate I have had a senior intern come to Washington. They come to Washington for about a week, and attend seminars on legislation that is pertinent to senior citizens. They return to the State and make speeches and give advice to our entire Congressional delegation and the Governor, and anybody else on some of the issues.

This is their program and it has been very successful. I know some of you here have applied for the program, but we can only take one a year into this group of legislative interns who do come.

Lucille did that this year. She has given some fine speeches. Lucille, I will call upon you at this time.

STATEMENT OF LUCILLE STAFFORD, IPSWICH, SD

Ms. STAFFORD. When I went to school I learned that they always saved the best for last, so I guess it is a good thing that Peg Lamont isn't here right now.

We all know that there is no fountain of youth. There is no way we can turn back the pages of time nor stop the aging process. That process begins the moment we're born, but medical science has made tremendous strides in its effort to slow down this natural phenomena and the life span of people has been extended and in turn multiplies the problems of our aging society.

Now according to statistics published just last week, the percentage of Americans 65 years and older has tripled since 1900. From 4.1 percent of population to 12.1 percent in 1986 and in 1986 there were over five times as many widows as widowers. There's a saying, "man's work is from sun to sun and woman's work is never done." Is that why women live longer?

There are four areas that I want to touch on and of course some of these have already been—I can relate to them and I must say that my first one is about our rural hospitals. If it hadn't been for our rural hospital that was opened in 1947, I wouldn't be standing here today.

My temperature shot up to 106 in the middle of the winter. If they had taken me to Aberdeen, I never would have made it. Our hospital in Ipswich closed over a year ago for the lack of a doctor. Government rules and regulations were basically some of the factors that contributed to its closure.

Not too many years ago this facility was enlarged and remodeled. It's a beautiful facility, but it's standing empty and hopes of it ever opening again are dashed. It opened up for a short time in March of this year when Dr. Photos came from Chicago, but it was not approved by Medicare for just a few simple, petty reasons.

And the horrendous costs of malpractice insurance and the lack of cultural activities in a rural area certainly doesn't attract doctors and their families. State and Federal governments do not permit a hospital to operate by itself like it used to years ago. The major concern for Ipswich right now is whether the clinic will be able to be saved in order that we still may have some form of physician services so that accident victims or the seriously ill can be stabilized for transport to the nearest hospital which is over 20 miles away.

And I can truly relate to that. My husband had to be taken by ambulance to the hospital last summer after our hospital closed and it was a draw between Aberdeen and Bowdle and that was over 40 miles away.

We do have two doctors in Edmunds County. Dr. McFee is at the Bowdle Hospital with clinic services in Roscoe, and Dr. Basil Photos is at the Ipswich Clinic but I understand that he may be leaving because of the fact that there is no hospital. They both give "in-house" service to the Ipswich Colonial Manor.

There is also a need in our area for more qualified E.M.T. personnel to administer first aid in emergencies. A nurse practitioner could help but that requires a nurse with a 4-year nursing degree and additional training, and due to so many controls this isn't very realistic. Additional training would take her out and away from her family as she would have to go to either Brookings or Vermillion.

Training closer to home could alter that situation. Someone mentioned to me that we should insist that children be put into car seats and that there should be a program mandatory like the "Just Say No" to drugs, otherwise many of our children will never live to be senior citizens like we are.

Now, the second issue that I want to touch on is the dollar sign. They have already mentioned that rural hospitals are not reimbursed percentagewise as the urban hospitals. Guidelines set by Medicare are not always applicable for all areas. What may seem right for one is not adequate for another.

Ipswich has a population of about 1,150 and many are retirees and senior citizens. since our area is almost 100 percent agricultural, those who retired and moved into town are now subsisting on a minimum Social Security benefit because farmers were not eligible

for Social Security until 1955, 20 years after Franklin Delano Roosevelt started the system to protect the elderly so that they could live out the sunset of their lives more comfortably and with free health care.

It was during those 20 years that farm income was at its peak. Then, in the 1950's and 1960's the elements here and low commodity prices really sliced into the earnings of that generation that was almost ready for retirement. When they started drawing benefits they got only the bare minimum.

Periodically a cost-of-living increase was added, but at the same time the increase in Medicare deductions swallowed their increases. I checked with Social Security just the other day, and I found that the maximum benefits are around $800 per month and in some cases even higher with an average of possibly $500. The minimum is less than $300 when the Medicare deduction is taken out, as 10 percent of their check is taken for Medicare premiums—and the maximum recipients contribute only 3.987 percent or less of their checks into the trust fund.

So, what did the last 3 percent cost-of-living increase do for those at the bottom? Nothing. But those at the maximum level received anywhere from $15 to $30 more, but no more was taken out of their benefits for Medicare premiums, so the rich got richer and the poor got poorer.

Even the very wealthiest taxpayers in America, people earning more than $200,000 per year, had their tax rates reduced 2 years ago. Now Congress has placed the full cost of Medicare "catastrophic" coverage on the backs of senior citizens 65 years and over. It is very unlikely that they will receive any benefits from the hospital part of that program because it only covers hospital stays of over 60 days, if I understand it correctly.

And only 3 percent of seniors even spend over 60 days in the hospital. Most seniors that have serious long-term illnesses like Alzheimer's don't spend a lot of time in the hospital either. They need skilled nursing to help provide care at home, and the new catastrophic care program provides only 80 hours of home care, only 80 hours, and then not until next year.

According to the Board of Trustees of the Social Security Trust Fund, Acting Social Security Manager Jo Miller of Aberdeen, reported last week that Social Security trust funds continued to increase in 1988 and will do so for many years in the future. They determined that the funds which pay retirement, survivors, and disability benefits will be adequately funded well over into the next century.

Now, during 1988 about 128 million workers made contributions to the Trust Fund. At the end of September 38.5 million persons were receiving monthly benefits under the program. Administrative expenses represented 1.2 percent of the benefits payments in fiscal year 1988. Income to the Trust Fund was $258.1 billion while outgo was $219.3 billion. Thus, the assets of the combined funds increased by $38.8 billion during the fiscal year.

There is still no law to prevent the Administration from using the Social Security trust funds to free up money for other Government bills. That happened in 1985, but 75,000 national committee members demanded the funds be restored with interest and they

were. Now this committee is working to stop this practice. This fund should be a separate fund so it cannot be dipped into, in an effort to balance the Federal budget at the expense of older Americans.

Most farmers retired when they felt they had set aside enough savings to carry them through, but with the constant rise in living expenses they soon found themselves at the bottom of the barrel.

Transportation is the third issue. Now this is another dilemma for our senior citizens. Since there is no bus service through Ipswich any more, the people are more or less isolated. Many of them are no longer able to drive and many that could can no longer afford to own a car, what with the high cost of upkeep, let alone the cost of gasoline.

Ipswich does have a senior citizens bus which schedules shopping trips, to clinics or doctor appointments, but this does not meet the emergency needs that exist from time to time, so in some ways one can compare our senior citizens in our locality to the homesteaders whose horse died.

Our fourth issue is care of our elderly—I think we all agree that times have changed and those changes seem to echo "new and improved." You see that all the time. Many changes are needed, but I oftentimes don't agree as to the "improved." I'm sure you've often heard the statement "how strange, one set of parents was able to take care of and raise a big family, but now not one family member can take care of the parent."

It used to be in what is called the good old days, and many of us recall them with a lot of fond memories, that the business, farm, or whatever the occupation was of the breadwinner, upon retiring, it was handed down to a family member. When the parent or survivor was no longer able to live alone, they were cared for by the family in their home.

There were no nursing homes, but we must remember that people are living to a much older age now, and, in those days hired girls were available. You seldom saw an elderly person in a wheelchair. None of the homes were even built or designed to accommodate a wheelchair. Now, with the standard of living that is embraced today, modern day conveniences have freed women from a lot of the drudgery, but it takes two paychecks to make ends meet.

So who is left in that home to look after an aging individual? The TV might keep them occupied to a certain extent, but no refrigerator, automatic washer, or vacuum cleaner can offer comfort in the dismal hours of pain that many senior citizens endure, and it couldn't help them in and out of bed either.

When visiting with one doctor, he felt that there should be more inspections of nursing homes, not planned ones, but those done unexpectedly. That way, he said, the elderly would be assured of decent and humane treatment. I have been a resident in a nursing home myself. I've seen it from the inside and the outside.

My mother-in-law was in one for 13 years, I certainly couldn't complain about the treatment that I got. It was a marvelous thing and the people that worked there have to be almost superhuman. I have to admit that.

But this doctor also felt there is a need for the overhauling of Social Security for the minimum recipients in order that they may

live with dignity. He was aware of the fact, with all the elderly that he sees, that some people's pets live better than some of the elderly.

In getting back to the old days, they used to have a lot of simple, tried and true remedies and it seems that some doctors are starting to pick up on them and find that they worked. Now, no one has really ever come up with a cure for the common cold, but for chest congestion, they used to use onion poultices, frying the onions in goose grease, placing them between flannel and putting them on the chest. I can see the logic in that because the steam and vapor from that was inhaled.

Now the steamers, that you plug in, take care of that. And they also had a cure for the flu. I only hope our Congressmen don't have to use it on any of us to cure our ills. To cure the flu they fixed a very large batch of hot toddy and hung their hats on the bedpost or head of the bed. They took a drink of the toddy and then rested in bed for a few minutes and then had another drink of the toddy and continued resting and drinking. When they began seeing two hats, they felt they were cured.

Thank you.

Senator PRESSLER. Thank you very much for your humorous, excellent presentation.

On the catastrophic issue I have joined Senator McCain of Arizona in legislation that would delay the implementation of the surtax. For example, Federal employees are covered under both the catastrophic deduction and the Federal insurance that they already have.

Many people have a Medicare supplemental insurance policy. I think the catastrophic health legislation was strongly supported by the American Association of Retired Persons. When it came to the floor, I supported the voluntary option. I think it's very important that we have a voluntary option. Hearings will be held on the catastrophic program.

Peg Lamont, I gave you a very fine introduction and I turned and you had disappeared. I told them about your work as a member of the Federal Council on Aging, your work on the White House Conference on Aging and your continuing work with the rural elderly. You are our final speaker.

STATEMENT OF FRANCES "PEG" LAMONT, CHAIRPERSON, SOUTH DAKOTA ADVISORY COUNCIL ON AGING AND MEMBER OF THE FEDERAL COUNCIL ON AGING

Ms. LAMONT. Thank you, Senator Pressler, members of the Senate Special Committee on Aging, and ladies and gentlemen.

Thank you for allowing me the privilege of running off to the airport. It wasn't easy today on Highway 12. I said goodbye to my daughter who is flying to Montreal on the 3:20 plane, so she should be lifting off right now. She doesn't get home that often and I took the privilege of being a grandmother and parent as part of my role. It just didn't seem right to let her go without being out there.

It's really a hard act to follow Ms. Stafford. You shouldn't have ended on that note because I'm not nearly as funny or good as that. I'm here with a couple of hats. I am honored to have this op-

portunity to speak at the hearing, first in my role as Chairman of the South Dakota Advisory Council on Aging and second as a member of the Federal Council on Aging.

I will conclude with a just few personal remarks that are all my own, related to goals for the rural older Americans. I have to remind you and Senator Pressler and the advisory committee that, in fact, each State has a council on aging. These are the representatives, the voice of the people, in those States and their concerns.

It's supposed to be the grass roots input and in the same way the Federal Council which is set up under law is made up of 50 people nationwide who are supposed to be there to be the grass roots input, the voice of the people, to stand up for the people to represent them from all areas of the country, and I represent the rural area, and speak to them.

We wish that we could reach even more of the area and we wish that people would remember to call on us on either the State or Federal level as often as possible. One of the exciting things about being on the South Dakota Advisory Council on Aging, of which I was named chairman just recently by the Governor, is that I had been chairperson way back when it first started in the 1960's and had been on it in many different roles since that time.

This centennial year in South Dakota marks the 30th anniversary of the first time the word "aging" was talked about in South Dakota for the first White House Conference on Aging and the preparation which began in the spring of 1959. And then it took 9 years until Governor Nils Boe yielded to the action by the Brown County Council on Aging set up by executive order, made funding, Federal grants, senior centers, head starts.

We were also celebrating last year the 28th year of all the first senior centers of this State. But, let me emphasize the fact that there is still so much more to do and we're just an example of many other States, although we are proud that we have pioneered many different areas of services that have not turned up and are just beginning to emerge in some of the other States.

The present State advisory council, and you have heard Gail Ferris, who is the Director of Adult Services and Aging, and she is our leader. We are the group across the State that works under her. We review grants, work with educational programs, legal aid to the elderly, all the things that she talked about also and we take a leadership role in recommending and supporting progressive legislation in behalf of older citizens.

Successful legislation in the past has included the improved revisions of the tax relief for the elderly, which has improved greatly the last couple of years, the revision of the guardianship laws, and a landmark law protecting elderly and disabled from physical abuse and financial exploitation. This latter law has been used successfully just this spring.

And one of the goals is to add the word "neglect" to the physical abuse because there are cases of planned neglect, not accidental, that happens and there should be some way of tracking that and taking care of that and it is really necessary.

Of special importance is the effort made by the South Dakota Council to support the Governor's comprehensive plan to provide funding and legislation which will help maintain independent

living for the elderly who are all at home. We are proud of the Governor's Initiative on Aging which Governor Mickelson spearheaded during the 1988 and 1989 legislative sessions.

It is exemplary of the long-term goals of the Council and is focused on encouraging the highest level of independent living possible for older South Dakotans. The plan, as you probably know, includes a six-step approach beginning with preadmission screening mandated for those entering nursing homes to find some alternative, if it is possible. It may not be.

In 1988, the legislature enacted a temporary freeze on the construction of new nursing homes. The State applied for a Title 19 waiver, a Medicaid waiver, similar to that used by some other States so that money could be diverted to follow the person to provide not just funding for the person in the institution, but funding for them in an alternative setting such as if they were at home—something of that sort.

And we also, through the legislature, had a housing task force that the Governor set up to review other alternatives and as the group increases, as I have pointed out in the tax relief for the elderly, expanding the ceiling and making the amount greater for the more and more low-income elderly to continue living in present homes or apartments.

Finally, there was extra money funded in both those years in the Department of Health and the Department of Social Services to provide more people, more full-time employees, who would provide the health care necessary to follow up on those persons trying to live at home and perhaps with certain moderately handicapping disabilities but were still able to be on their own if they had some help. This is summarizing it very generally.

But it is a combination of intensive effort to provide support for those able to live independently and it is showing significant progress and is the most effective approach, we feel, to quality of life for older South Dakotans. Although still in its initial trial stages, alternatives in housing and increased support from the State for the low-income elderly is having great acceptance statewide.

And there's increased employment of elderly. More people are wanting to work even in the later years if there are jobs and jobs should be encouraged. We already have the program RSVP, Foster Grandparents, Senior Companions in Sioux Falls, and Green Thumb, which provides some volunteer and also some part-time work in some cases, some transportation and means in some cases.

Money spent on these programs multiplies the benefits manyfold, and these moneys come not from the older Americans, but comes from other sources and should be looked at as an increase because it's one of the greatest benefits we can have for the elderly, with the use of volunteers and the part-time worker out in the field keeping them healthy and happy and serving other people at the same time.

South Dakota pioneered support programs for Adult Day Care way back in 1967. South Dakota had, I think the first Adult Day Care program in the Nation. And now it has Adult Foster Care, Respite Care, and a variety of in-home care and it is very important to see that those programs continue.

I would like to speak now going from some of the things that are happening in the State—change my hat—and speak as a member of the Federal Council on Aging. I'm one of 15 members. I was appointed first by President Reagan in 1982, reappointed and was appointed by the U.S. Senate in 1987 through 1990.

We meet quarterly, but we are charged under law to report directly to the President and to the Congress, so in doing testimony today I'm doing my civic duty in reporting to Senator Pressler's committee. We constitute a cross-section of rural and urban older Americans.

My personal goal is to focus on the special needs of the rural elderly because ever since I've been on the national Federal Council, I have found that most of the members are from urban areas. I am one of the few rural members. We now have a person from Iowa and someone from Kansas. I'm one of the few that comes from a State with a geographic distance such as we have in South Dakota and the nine Indian reservations.

It is very important that we get our recommendations across. We find that we have a very remote profile. People have never heard of the Federal Council on Aging. They get it mixed up with the National Council on Aging which is a very large group with hundreds and thousands of members and AARP which also has hundreds of thousands of members, but we are established under law as a small 15-member group to be the grass roots spokespersons for all of you and all those in our Nation, and it's a tough job.

The annual report is required by law and I just got this the day before yesterday, so I'm sure that it has already gone to Senator Pressler's desk because under law it is required to go to the President and to each Member of the Congress, especially to the two Special Committees on Aging in the Congress. It tells what we have been doing and how we are trying to work in behalf of the people nationwide and to bring some understanding of the needs nationwide that might be lost, that might be hidden.

So it's very important that people understand that they can speak to the Federal Council members and give us recommendations. One of the things I was delighted about was when I heard Mr. Muth talking about the frail elderly. It was a report by the Federal Council on Aging, a study, called "The Frail Elderly" that was done in 1970 before I was on the council, that started the use of that name as one that signifies the oldest and the most desperately delicate and fragile of all of our older people. That is a pretty good word gone over and over again nationwide and so now we use it as if it were an every day word.

Some of the other things that we have accomplished in the past—we had a study about 8 years ago which was the first time there had been an extensive criticism of the role of both the family members at home and the nursing home people that take care of people and the problems they have that has become a classic publication, as well as our report on hypothermia and some of the other things of that sort.

So these are some of the things the Federal Council does. In the last year we had a contract, a grant to the University of Illinois, Department of Gerontology, to do an extensive study on the possibility of a White House Conference on Aging for 1991 and to make

it workable, practical, economically feasible, and to see if it was worth doing, and then to report these findings and the plan to the President and to the new Secretary of Health and Human Services, Dr. Louis Sullivan.

This was done, including a massive hearing held in San Francisco last November in which every organization who worked with the elderly, from the Association of Hispanic Elderlies to the blind elderly all testified to what they would like if we did have a White House Conference. Was it worthwhile to spend the money on this report? The conclusion of these people was yes, it was needed.

There should be a type of review of where we have been and where we must go because with people living longer and a greater need to care for them we must find out what those needs are and so that recommendation went to the President. Whether the budget deficit will be able to recommend one, we do not know. It depends on the President to call such a council, and he may feel that it's not practical with all the pressures of today's world in other areas, but that was one of the major things we did last year.

I chaired what's called the Targeting Committee. Targeting is very complex, because we talked about the fact that the Older Americans Act requires by law each State to target funds for low-income and minority people based on a formula, and there is a difference between a formula for those interstate and those intrastate. There were some court cases in several areas in Florida but these formulas have had different interpretations so we've had to study that.

I chaired that committee and got input from people nationwide on that. Agencies working with the elderly, because there is what is called the "hold harmless" clause in the Older Americans Act that prohibits targeting on an interstate basis, while it requires it on an intrastate basis.

We are asking you members of the Special Committee on Aging to remember that the Federal Council on Aging has recommended last year and reinforced that recommendation this year that those words be reviewed and looked upon if at all possible for making that funding more precise so that we can target the funds where they are needed the most without getting tied up in legal problems.

In addition, the Older Americans Act needs clarification, we think, as members of the Federal Council, and we have recommended to the President and the Congress and the committees on aging that the word "adequate" which is used—what is adequate funding? How do you define the word adequate? This is a very difficult task for various States to define when talking about adequate funding to the low-income minority people.

And we ask that in the absence of abuse of discretion as determined by the Commissioner, subject to judicial review, the States' determination under section 306(a), section 2, shall be final.

The Council stills feels that this is an urgently needed amendment to the act.

In a lighter mood, the 1988 Federal Council spearheaded a study of guardianship standards and guidelines as the quality of life effort. We all know that there are times when an older person with Alzheimer's disease or some other various difficult condition has to have a guardian but the laws of the State are varied so much and

there have been times when it has taken away the rights of the individual completely.

The American Bar Association met with the Federal Council on Aging and we sent out recommendations to all 50 of the States in mailings of the model laws. We have been encouraging all the States to review and change their laws to make them more humane to protect the rights of the individual.

In other words, they should be flexible. If a person has a guardianship and suddenly recovers, the guardianship should be such that it can be reversed. There have been cases which some of you have seen on 20/20 and on the news that happened in the State of Michigan who were not qualified to be guardians were guardians and were, in fact, taking money from the elderly people who have no recourse.

Twenty-two States have responded to the Federal Council regarding the standards and guidelines. South Dakota is one of those States. In the past two legislative sessions South Dakota has passed several new laws that have updated and reformed existing laws which were already much better than many of these other States I have talked about. So we should be very pleased about that, but we do have to continue urging that the Federal Council stand firm in the belief of a most careful guardianship to keep people from being taken advantage of, and misused and having their rights taken away from them.

Finally, the Federal Council recommends that the Department of Housing and Urban Development maintain the Low Income Housing Tax Credit for nonprofit corporations to stimulate safe, affordable housing for older people. Employment of the older worker has always been a goal for the Federal Council and we wish to emphasize the need for more opportunities for jobs.

In conclusion, as an individual, I wish to emphasize some of these points. In 1977 when I went to the first White House Conference on the Handicapped as an observer, representing at that time Governor Kneipe, we were told that within a few years every State would have adequate vans for transportaiton that would have easy access for the handicapped. The States would have vans that "kneeled down," bent over on one side to let the person go in as well as the vans with wheelchair access.

It was a glorious forecast, but now nearly 9 years later some of that has come to pass. We do have some handicapped vans statewide, but it is far from the goal that we need to keep our rural people active and able to access various services.

The intergenerational programs and services are necessary because of the fact that older people are working more closely with youth now and it should be a cooperative effort. We have to create new health plans, new jobs for the able oldsters and new recreation and rehabilitation for the less active older person.

America needs a spokesperson for the older American in the Cabinet or on the President's staff to speak and interpret the requests and concerns of this growing population of older Americans. It's time for an ombudsman to serve as a pipeline to the President to convey the messages of the elderly to him and to the Cabinet and to serve as a catalyst and liaison for him. Our States already

are working for them, but on a national level we need such a person.

Perhaps the late Claude Pepper was that type of person. The aging need someone in a job role who can be the liaison from the people to the President.

Speaking finally for the rural elderly, there is always one primary hope we all share—and we have stated it over and over again—to remain as active and independent as possible. These older South Dakotans and prairie people are rugged, of pioneer stock, celebrating their 100th year of South Dakota statehood.

Yesterday I visited a 92-year-old friend. She said to me "But what use am I? I want to be useful and active and I'm not." And then a few minutes later she gave me six or eight beautiful cucumbers and green beans from her garden, and I told her that she was an inspriation to me and to other people and that she shouldn't worry about being useful, she was being useful. She didn't believe me. She wanted to be more independent, she wanted to do more things.

That's really the cry of almost all rural older Americans, whether they're out at Eagle Creek, whether they're out on the prairie where they can't get transportation into town or get to a doctor. Because without transportation, we lack the key. It saves lives, it provides access to services, and in the long run saves the Nation from the grief and financial burden of long-term care.

Anything that we can do in providing independent living is the goal that all of our members have.

Thank you very much for listening and for giving me this opportunity, Senator Pressler.

[The prepared statement of Ms. Lamont follows:]

TESTIMONY FOR THE U.S.SENATE SPECIAL COMMITTEE ON AGING AT THE HEARING HELD AUGUST 7,1989 by U.S.SENATOR LARRY PRESSLER AT THE ST. LUKES HOSPITAL WELLNESS CENTER,ABERDEEN,SD.

From: Frances " Peg" Lamont, PO Box 1415,Aberdeen,S.D. 57402
Chairperson, South Dakota Advisory Council on Aging and
Member, The Federal Council on Aging

The Hon. Larry Pressler, U.S.Senator, and members of the Senate Special Committee on Aging,:---

Senator Pressler, Members of the COmmittee;--I am former State Senator Frances " Peg" Lamont, Aberdeen,South Dakota, chairperson of the South Dakota Advisory Council on Aging by appointment of Governor George Mickelson, and member of the Federal Council on Aging 1982-1990, by appointment formerly of President Ronald Reagan, and since 1987 by the U.S.Senate.

I am honored to have the opportunity to speak at this hearing, first in my role with the South Dakota Advisory Council, and second, as a member of the Federal Council on Aging.I will conclude with a few personal remarks related to goals for the older American.

South Dakota's Advisory Council on Aging was established by executive order of then Governor Nils Boe in 1967 following action by the Brown County Council on Aging which I chaired at the time. After serving as S.D.delegate and planner for the first White House Conference on Aging 1959-1961 under a short term federal grant to the state, my determination to see that my state joined others in establishing a full fledged department on aging became the goal Without a state office on aging,no federal funding,programs or services could be developed.This past year South Dakota celebrated not only its 100th birthday,but the 20th year for the first senior centers ,multi service programs, transportation, and in-home care.As pilot chairperson,I was privileged to speak on the struggle from 1959 to 1989 which has brought about a comprehensive network of programs making South Dakota a leader in action for the elderly, especially rural elderly.

The present state advisory council reviews grants,works with educational programs,legal aid to the elderly, and takes a leadership role in recommending and supporting progressive legislation in behalf of older citizens. Successful legislation has included revisions of the tax relief for the elderly laws ,revision of guardianship laws,and a landmark law protecting elderly and disabled from physical abuse and financial exploitation.This latter law has been used successfully [illegible]

Of special importance is the effort made by the Council to support the Governor's comprehensive plan to provide funding and legislation which will help maintain independent living for the elderly.

The South Dakota Governor's Council on Aging is proud of the Governor's Initiative on Aging which Governor George Mickelson has spearheaded during 1988 and 1989 legislative sessions. It is exemplary of the long-time goals of the Council and is focused on encouraging the highest level of independent living possible for the older South Dakotan.

The plan includes a six step approach beginning with pre-admission screening mandated for those entering nursing homes.In 1988 the legislature enacted a temporary freeze on construction of new nursing homes.The state applied for a Title 19 waiver in order to divert funds for an accelerated effort to provide alternative programs and living arrangements.Housing options were redefined and a Governor's Housing task force studied alternatives.The legislature approved increases in the tax relief for the elderly law as recommended by the Governor, expanding the ceiling in 1988 and in 1989 voting a significant increase in funding to assist low income elderly to continue living in present homes or apartments. Additional funding and an increase in the number of full time employees in both health and social services departments enabled the state to upgrade and expand home health care programs to enable more elderly to continue living at home despite illness or moderately handicapping disabilities.

This combination of intensive effort to provide support for those able to live independently is showing significant progress and is the most effective approach to quality of life for older South Dakotans.Although still in its initial trial stages, alternatives in housing and increased support from the state for low income elderly is having great acceptance state-wide. Encouragement for employment of the elderly is also bringing about increases in job opportunities. Programs such as RSVP, Foster Grandparents,Senior Companion, and Green Thumb are popular and could double in size if funding were available.They provide both volunteer and work programs ,transportation,and some provide meals.Money spent on these programs multiplies the benefits manifold.

South Dakota pioneered su-port programs of Adult Day Care, and provides Adult Foster Care,Respire Care and a variety of in-home care.

In speaking as a member of the Federal Council on Aging, I note that I am one of fifteen members charged under the Older Americans Act to serve as grass roots representatives for the nation's elderly, speaking out in their behalf,and reporting directly to the President and the Congress.At least nine of us must be older individuals.We constitute a cross section of rural and urban older Americans.My personal goal is to focus on the special needs of the rural elderly based on experience in SOuth Dakota and the prairie states.

The Council is required by law to prepare an annual report to the President,members of the Congress and other interested governmental and private agencies.This report,has been distributed ,and you may have already read it, but I have copies here which describe the public hearings and activities of the Council during 1988.The Federal Council works intensively to bring to your attention the special needs of the nation's older citizens.We hope you will take time to read this report with interest.

In 1988 each member of the Council served on the White House Conference on Aging committee.I chaired the committee on Targeting of services to the low income and minority elderly.Other committees included Quality of Life and Housing, Public Education and Employment, and Health and Insurance.

The Council met four times, and shared information and minutes with 82 organizations, ranging from the Advisory Council on Intergovernmental Affairs to the National Institute on Aging, to the Villers Advocacy Associates.

During 1988 action by the Council let a contract to the University of Illinois to develop an orderly, relevant, and economically feasible plan for a potential White House Conference on Aging 1991.Part of the study included a forum held in San Francisco in cooperation with the Gerontological Society of America Conference when 27 witnesses reported for national organizations concerned with Aging.Copies of the report prepared by the University of Illinois were presented to the President and the Secretary of Health and Human Services.

At the August 1988 meeting in Washington,D.C.the Council studied the problems relating to the intra state targeting of federal funds to the Older Americans Act . The goal is to target OAA funds to older low-income minority individuals in the greatest economic or social need,but the Council learned that in some states this issue has become entangled in legal action related to confusion and differing interpretations of the formula.There is special difficulty faced by those States with extremely large numbers of economically and socially needy minority older Americans xaused by the "hold harmless" clauses in the Older Americans Act that prohibits targeting on an interstate gasis, while requiring it on an intrastate basis.

The Council also learned that the word "adequate" in the OAA continues to need Congressional clarification. In its 1986 recommendations to the President and the Congress, the Federal Council suggested." In the absence of abuse of discretion as determined by the Commissioner,subject to judicial review, the States' determination under Section 306(a) (2) shall be final". The Council still feels that this is an urgently needed amendment to the Act.

In 1988 the Federal Council spearheaded a study of Guardianship Standards and Guidelines as a Quality of Life goal.In a May forum in Washington members of the Federal Council continued to caution against the arbitrary removal of autonomy from potential guardianship wards while protecting them through this legal intervention of last resort.The Council worked closely with the American Bar Association,the Center for Social Gerontology, the National Conference of State Legislatures and other agencies in defining guidelines for guardianship. In recommendations, the Council endorsed the rapid implementation of guardianship programs and laws for the benefit and protection of older Americans as found in the recommendations of the American Bar Association, and voted to send copies of the Standards and Guidelines for guardianship to each of the 50 state departments of human services and aging. Twenty two states have responded to the Federal Council regarding the standards and guildines.South Dakota is one of these states.In the past two legislative sessions new laws have passed to provide guardianship with emphasis on the rights and protection of the elderly.A guardianship law should be one which can be reversed as conditions change, recommendations indicated.

The Federal Council participated in the publication of AGING AMERICA, a book of trends and projections.Over 19,000 copies were distributed nationwide.In mid-year, an additional 5000 copies were authorized to supply the Natl Federation of State HIgh School Associations with research on the 1988-89 Debate Topic which dealt with the graying of America.

In the realm of Long term Care Insurance, the Council in November of 1988 passed a resolution urging the insurance industry to face the need for an unified policy clearly stating its role in creating a viable place for private long term insurance..Unless an incentive such as a tax credit for premiums on a long term health care contract is offered,many Americans would not be motivated to plan for the future, it was felt.

At the June 1989 meeting, the Council looked with concern at the Catastrophic Health Care plan, and passed a resolution of concern for the impact of the financial responsibility of elderly under the present act .

In future goals, the Council considers the plan for a 1991 White House Conference on Aging a workable,practical format for the use of the new Secretary of HHS, Louis Sullivan, should the President choose to call such a conference.

The committee will continue to study intrastate funding formulas in the distribution of Federal Funds with hope that an improved formula will make targeting more effective.

The Council continues to speak out in behalf of increased funding of Title VI for Indian Reservations to meet critical needs.The change in the formula of distribution has benefitted some tribes but drastically cut others.This is a rural need of great concern to states such as South Dakota where we have nine reservations and areas of desperate poverty .As an example, where there were once eight nutrition sites on the CHeyenne River reservation, there are now two.Well balanced food is important,for diabetes is rampant.Many of the commodities furnished to the nutrition sites are heavily fatty or high in sugar content,exaclty the wrong diet for diabetics, but what nutrition sites they have, attempt to provide correct balanced diets despite the roadblocks in funding and food supply.

Transportation for rural areas is funded on a population formula in many cases,yet studies show that rural transportation is more costly than urban.and actually requires more money.Rural elderly cannot avail themselves of nutrition sites,blood pressure clinics, visits to the doctor, or social events unless they have transportation to get to the site where the service is offered.In the vast open spaces and sparsely populated Dakota prairies, transportation is the key to services to the elderly,both on and off the reservation.

The REA, Rural Electrical Assosiation recently sparked a study of isolated elderly and the prevalence of clinical depression found among them. Lack of contact with other people,with services, even with church and social events,can trigger depression in older rural folk. Creative uses of funding to provide rural networks of transportation must be encouraged.

The Federal Council is also recommending that the Department of Housing and Urban Development maintain the Low Income Housing Tax Credit for non-profit corporations to stimulate safe,affordable housing for older people.

Employment of the older worker has always been a goal of the Federal Council, and along with services to maintain independent living, the council urges all Americans to recognize the potential of the elderly in the work force,and to provide opportunities for jobs.

In conclusion, as an individual, I wish to emphasize some of these points. In 1977 at the White House Conference on the Handicapped which I attended as the Governor's Official Observer for South Dakota, the promise of transportation with buses which "kneeled down" for access, and were to be provided nation-wide for the handicapped,all with inter-com, has been slow in fruition,although SOuth Dakota now has many well equipped vans with hydraulic lifts and safe vehicles for older riders.The promise is still far from coming true as promised more than 12 years ago.

In South Dakota,it is 30 years this summer since the first step was taken to talk about the dignity,the needs, and rights of the elderly.I have been privileged to have served continuously on the planning councils for the state's White House Conferences on Aging since 1959,and to have attended all three past Conferences, and I personally hope that a 1991 Conference on Aging will be called.It is time to re-evaluate the goals, to change direction and focus on new aspirations based on the continuous change made possible by the increased longevity of Americans.It is a time to plan Intergenerational programs and services ,to create new health plans,new jobs for the able oldster, and new recreation and rehabilitation for the less active older person.

We need a spokesperson for the Older American in the Cabinet or the President's staff to speak and interpret the requests and concerns of this growing population of Older Americans . It is time for an "Ombudsman" to serve as a pipe-line to the President conveying the messages of the elderly,and serving as a catalyst and liaison for them.

Speaking for the rural elderly,there is always one primary hope shared by all--to remain as active and independent as possible.These older South Dakotans and prairie people are rugged,pioneer stock, celebrating their 100th year of South Dakota as a state."What use am I?"said a 92 year old woman to me yesterday."I want to be useful and active".Then she gave me fresh cucumbers and green beans from her garden,planted,and gathered by her.But she wanted to be even more independent--and that is the cry of almost all rural Older Americans. It takes federal funding to provide the services,the t ransportation,

the programs, but it saves lives, and in the long run, saves the nation from the grief and financial burden of long term care. **

THANK YOU VERY MUCH

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Member the Federal Council on Aging 1982-1990
Former State Senator,Dist. 2,South Dakota

** On June 14,1989 I received the Louise B. Gerrard Award for Congribution to Rural Older Americans from the National Association for of State Units on Aging,(NASUA), the state governmental units which manage funding for Aging nationwide.These personal thoughts above are among my concerns expressed at that meeting on receipt of the award.

Senator PRESSLER. Thank you. I'm told that we're running out of time, but we will have a question and answer period. A staff person will be at the end of each table with a microphone. We have time for just a few questions. If you will keep the questions fairly short, we'll get the answers from the panel here.

Mr. WELLS. I'm R.G. Wells from Aberdeen. Dad was in a nursing home here in Aberdeen for approximately 8 years, so I'm addressing that point.

Let me just say that the problems in politics are connections. One connection is military spending versus medical spending. Somehow the administration that you are a part of, Senator Pressler, went off on a huge tangent with this military spending and now we find ourselves in a big debt and also with not enough resources to take care of things that are really important—housing, medical care, education, etc.

But, getting to the particular—I've met with Mr. Muth on several occasions when Dad was in his nursing home. I must say I came away with a negative feeling, that they were not providing as much asssistance as they could. It was very good in terms of friendliness, of personal body care and the institution. However, Mr. Muth did not come in and inspect without prior notification. He did not see all the things that I saw when I went in unannounced.

Dad wasn't getting adequate care in terms of being fed. The food often was cold. I could not get an adequate response. Well, what can you say? I challenged Mr. Muth. I believe, like he does, that the most underpaid are the most important—the aides. And if he would agree with me that we should do something about this, I would match his funds, if I could, to assist the aides in getting some kind of special recognition and some kind of financial reward

And I mean your funds, not the church's funds, but your personal funds. Put your money where your mouth is, that's what I say. Nurse aides should get training. An ombudsman should come in here, like Ms. Stafford said, and without prior notice check on these things. That is very important in these nursing homes. I believe your father is in one, Senator Pressler, is that correct?

Senator PRESSLER. Yes.

Mr. WELLS. Right. Dad was in almost 9 years.

Senator PRESSLER. Thank you, and let me respond in part by saying that I have been very impressed with the dedication of the people in our nursing homes. I know mistakes are sometimes made, but I have been impressed in South Dakota by the dedicated service people get. I think it's one of the best in the country.

Mr. Muth, do you want to make any comments on what has been said here?

Mr. MUTH. Very briefly, I think I have said it occasionally, that I am sorry Mr. Wells and I did not yet come to some resolution about our differing thoughts. I think the one thing he did say today that I would truly agree with him on, is providing resources for the people working in nursing homes. Our society has to do that. As a product of this society, I'm certainly willing to put my money where my mouth is. My money wouldn't make much difference, but society's would.

Senator PRESSLER. Mr. Schuman.

Mr. SCHUMAN. My name is Steve Schuman. I sell insurance and spend considerable time with senior citizens. My question will pertain to hospital and doctor charges in and around the Aberdeen area. For example an appendectomy would cost roughly $650. In Portland, OR, the same procedure would cost double that amount. Is there a possibility, Senator, that we can put a cap on this type of thing? In other words, if it's going to be $850 or $650 here, how about $850 in Portland or vice versa as the case may be?

What I am suggesting is a national cap on the amount that doctors and hospitals can charge. I realize that I may offend some doctor and hospital representatives here today by making that statement.

The second thing I'd like to bring to your attention concerns approved and unapproved charges by Medicare. As I have progressed in my insurance career I have discovered that there are an increasing number of items that are not being approved. Items that up to 3 years ago were being approved are not being approved today, and I wonder why. Why are we having that lower approval rate or nonapproval rate of things that were being approved a while back?

I would recommend given the large number of Medicare supplemental policies available on today's insurance markets that all items should be approved by Medicare, at least within 5 cents or 10 cents. There are several company representatives in South Dakota and the United States that will pay the balance that Medicare does not if Medicare approves any portion of the bill.

In other words, if someone has an approved payment by Medicare of 5 cents on a $385 bill—and I have a client that this has happened to—then the insurance company paid the entire bill. Why not have 100 percent approval rate across the board? Let the insurance companies assist our senior citizens in keeping those medical costs down.

Finally, I would like to address one comment to Dr. Mulder. His third point was rationing of health care. One procedure he mentioned was hip replacement overseas. At age 67, you can't get a hip replacement overseas anymore, so what happens. The overseas people come over here to get their hips replaced or whatever the transplant may be.

Within the United States, things are bordering on genocide, in other words, the killing of the elderly. Check California legislation. They are trying to get genocide in there. I deal with these elderly every day, Senator, and I don't want to see any old person be put away like an old dog. Thank you.

Senator PRESSLER. Thank you.

I'm going to call on Dr. Mulder for a response. Referring to the first part of your statement, that's the essence of what we're trying to get—some equity in the cost Government pays in some of these extremely high cost areas. Essentially, every one in this room is subsidizing the high cost areas, even Dr. Mulder.

Dr. MULDER. That's what we have been working on for the past 5 years, his first point, that we have a fee schedule.

Because you pay the same taxes you get reimbursed at the same level. If they want to pay the doctors in New York five times as much for doing the same thing then they should charge the seniors there five times as much payment. It's so simple to me. So the

Health Care Financing Administration then authorized, and Congress appointed, the Physician Payment Review Commission a few years ago and they authorized the AMA and the Harvard Medical School to study this.

They came up with a resource based relative value scale (RBRVS), which is a fee schedule. And just this spring, the Physician Payment Review Commission (PPRC), recommended to Congress that they accept this fee schedule which would effectively level the playing field and reimburse everybody in this country eventually the same amount because they would be paying the same premium.

They want to attach to that what we call "expenditure target." I don't want to get into that too much. Basically, the AMA is against it. Basically, the American Academy of Family Physicians is for it, with some restrictions.

So far all the cost cutting we've had in medical care in this country has been even, across the board.

But in rural America you are reimbursed generally 40 percent less for everything you do than you would be in urban America. It is harder and harder to do anything about it. Fifty percent of the people in this country live in 37 cities. It's hard to fight those big cities.

Fifty percent of the Members of the House of Representatives are from nine States. It's hard for the other 41 States to fight those 9 States. We have a majority (two-thirds of the Senators in the Senate), who are on our rural coalition. We are getting our biggest help from them. But in the House of Representatives we can't get even half of them to be on a rural coalition to do anything about it.

The reconciliation that is going on now not only is to reimburse hospitals the same, but to reimburse senior citizens for out-patient medical care the same. The bills that are sponsored want to start next April and then gradually phase it in over the next 5 years. I'm concerned that 5 years from now when 14 of your hospitals are closed in your State, it's going to be too late. So we want somebody to do something now.

The Social Security Act of 1965 started Medicare January 1, 1966. It based reimbursement on what was being charged by doctors out here in rural South Dakota in 1963. They haven't changed that reimbursement formula hardly at all. But since then we've been able to get better technology in Aberdeen or most rural hospitals in this State. We can no longer compete with the quality of medical care that they have in any big city and it is time now that Government funds cover everything equally.

Senator PRESSLER. Thank you very much for explaining the increased awareness of rural health care in the Senate. The main responsibility falls to us because in the House of Representatives, the large cities have sometimes 30 or 40 Representatives from one metropolitan area, mainly New York or Los Angeles. So we do have a great deal of extra responsibility in the Senate.

Mr. RAND. A lot of medical care for elderly in this State is provided by mid-level practitioners. Currently we're in a crisis. We have 17 positions right here in South Dakota that we cannot fill because we do not have any mid-level providers. Part of the reason for that is most training programs for mid-level providers are locat-

ed in urban areas. They find jobs in the urban areas and stay there. Something that I think Congress needs to look at is the development of training programs in rural States where rural people will be included into those particular programs if they would stay in the rural States.

We found this was true through our medical school in South Dakota. Fifty percent of those people who were trained here, and recruited from here remained in practice in South Dakota. I think we would find the same thing in training mid-level providers.

Presently, there are 50 new programs in this country that are paying mid-level providers to create new jobs. The attempt to fill those jobs is overwhelming.

The second point is something you and I have heard over the past 3½ years. It deals with the use of mid-level providers in nursing homes. We were able to get changes in the conditions of participation.

The new regulations for nursing homes were to go into effect 5 days ago, on the second of August. That has been delayed now until the first of January 1990. This depletes the number of providers in the nursing homes and caring for the elderly. We have multiple nursing homes in this State where the only medical practitioner is 70 miles away. A nurse acts as a physician assistant. At this point in time we cannot do this legally and provide care.

I have been operating a rural health clinic in Pollock and Herreid. Herreid has a nursing home. If patients come to the clinic, I can take care of them. If I go to the nursing home to see them—and some of these patients are very difficult to transport—I'm violating the conditions of the Federal law. In other words, the nursing home can lose their license for allowing me to do that. The proposed rules need to be put into effect.

Senator PRESSLER. Thank you very much.

I would like to thank the people who traveled to be here today. We have a lot of people who have driven for 4 hours. We've reached the time when we are supposed to be finished with the room. I thank you all very much.

[Whereupon, at 3:45 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

Item 1

MEDICARE REIMBURSEMENT AND RURAL HEALTH CARE

by Richard D. Mulder, M.D.

ABOUT THE AUTHOR

Dr. Mulder is a board certified Family Physician who has been in solo practice in Ivanhoe, Minnesota, for 19 years. He was raised in the small community of Rock Valley, Iowa. He attended South Dakota State College in Brookings, South Dakota and received his Pharmacy degree in 1966. After attending the University of South Dakota at Vermillion, SD, he then received his M.D. degree at the University of Iowa in 1968. After a rotating zero internship at McKennen Hospital in Sioux Falls, South Dakota, he permanently located in Ivanhoe.

He has been active in all aspects of organized medicine, medical education, and medical research. He is a past president of the Minnesota Academy of Family Physicians.

In 1987 he was awarded the Bush Clinical Fellowship to do more extensive study in the areas of Geriatric Medicine and Rural Health Care. Therefore, it was after 10 years of formal medical training, 19 years of clinical experience, four years of special interest in rural health, and more then a year of concentrated study that he was able to formulate his evaluation on problems concerning medicare reimbursement and rural health care.

SUMMARY

Medicare patients in Minnesota are subsidizing the medical care of medicare patients in large urban coastal cities in an amount exceeding **ONE BILLION DOLLARS** a year.

Medicare patients in all rural areas of the United States are subsidizing the medical care of all urban senior citizens in an amount exceeding **EIGHTEEN BILLION DOLLARS** a year.

The reason for this tremendous loss of money from rural America is entirely due to a two-tiered system of medicare reimbursement, whereby senior citizens in urban America are being reimbursed more for their medical care then are rural senior citizens. And they all pay exactly the same Medicare Part B premium.

The fact that this two-tiered system has existed for 23 years has been responsible for **BILLIONS AND BILLIONS** of dollars of wealth being transferred from rural America to urban America. This fact may be a main contributing factor responsible for many of the rural economic problems, and the rural health care crisis that now exists.[42,62]

MEDICARE HISTORY

1965--The Social Security Act was adopted and the Medicare and Medicaid systems were formalized to begin in 1966. Under section 1833 of the Act, medicare payment for most medical services and procedures are provided for under Part B of the program. Payment was made by Medicare contractors known as carriers based on reasonable charges made by physicians in 1963.

With no "High-Tech" medicine being practiced in rural America in 1963, there was an inherent disparity in the amount of reimbursement. In fact, in Minnesota, two separate carriers were used. Travelers Insurance Co. was used for a high level of reimbursement in the Twin Cities and Rochester, and Blue Cross & Blue Shield was used for lower reimbursement in rural Minnesota. Payment was based on the lowest of these four factors:[20]

1. The actual charge.
2. The customary charge for similar services generally made by the physician furnishing the service.
3. The prevailing charge in the locality for similar services. This was set at the 90th percentile level.
4. Other factors that are necessary and appropriate.[2]

1969--The prevailing charge was lowered from the 90th percentile to the 83rd percentile of area charges.

1970--The prevailing charge was lowered to the 75th percentile where it is today.

1972--A Medicare Economic Index (MEI) was created by Congress to limit the rate of annual increases in prevailing charges.

1973--Wage and price controls were lifted for most of the economy, however, all controls were retained for physicians for an additional 15 months.

1976--MEI or The Medicare Economic Index was applied to prevailing limits. This index was applied to the 1973 prevailing charges which were originally based on the 1971 charges.

1982--TEFRA, or the Tax Equity and Fiscal Responsibility Act, required hospitals to contract with PRO's or peer review organizations.[19]

1983--DRG's, or the Diagnosis Related Groups, were enacted as part of the Social Security amendments.

1984--DEFRA, or Deficit Reduction Act, created "participating" and "non-participating" classes of physicians and also FROZE reimbursement levels for customary and prevailing charges from June 1, 1984 to September 30, 1985 and was based on the 1983 level.

1985--EEA, or Emergency Extension Act, extended the Price Freeze from September 30, 1985 to March 15, 1986.

1986--COBRA, or Consolidated Omnibus Budget Reconciliation Act, replaced the freeze with the complex maximum allowable actual charge (MAAC) for non-participating physicians. Participating physicians were allowed a 3.2 % increase in charges over their 1986 levels.[19]

WHAT ARE THE RESULTS OF THE ABOVE LEGISLATION

Even though all Medicare recipients are paying the exact same premium of $24.80 per month for part B Medicare, they were being reimbursed at widely different levels for the exact same service right from the start.12 These payments should not be considered as physician payments. Most physicians did not take assignment at the beginning and billed their patients for their charges. Only 15% of rural physicians and 17% of urban physicians in Minnesota, take assignment on all their medicare patients. However, all non-participating physicians occasionally take assignment on selected patients.58 Also, from the beginning, the senior citizens in large metropolitan coastal cities were reimbursed at much higher levels than those senior citizens in rural America.12 The net effect was that rural citizens had to pay more from the start.

These differences of reimbursement were only magnified by subsequent legislation and the use of the Medicare Economic Index. The gap, or difference in reimbursement in 1988, is much larger then it was in 1965.

All services and procedures are described by CPT codes. These are listed in the American Medical Association's, Physicians' Current Procedural Terminology, now in its fourth edition of 1987, (CPT-4) There are about 7000 different codes.

There is also a different reimbursement based on whether or not the service was provided by a medical specialist or a non-specialist, with a much higher level of reimbursement to patients treated by a specialist.

Another area of disparity was that different specialists were set at different levels of reimbursement.51 So a patient having, for example, a skin biopsy done by a plastic surgeon would be reimbursed at a much higher rate than the patient who had exactly the same procedure done by a general surgeon.

Medicare has set up 240 different payment locations7 in the United States.2 And they reimburse the Medicare patients in those areas at widely different rates. This difference is based on variations that are almost impossible to measure and probably do not even exist today, as they may have existed in 1963. These include differences in living costs, malpractice premiums, quality of care, physician supply, and other equally difficult to define factors.2 The Prospective Payment System, or PPS wage index, is the hospital wage index used to adjust payment rates. This index was developed by the Health Care Financing Administration (HCFA), and is based on average hourly wage costs. It doesn't make sense that a wage index could be used to reflect costs such as office rent, office equipment, or malpractice insurance. It is an indirect index at best.21

The Medicare system as created for itself a "monster" of a problem. With 7000 different codes and 240 payment areas and 44 different specialties and a completely different system for non-specialists they must be having a computer nightmare trying to keep tract of the hundreds of thousands of different reimbursement possibilities. There has been no printing of this confidential information since 1984. Now if you want the information you have to order it on computer tape and it will cost you over $1300.00. It also has to be a very expensive system to administer. To end up with a system that is so basically unfair to our rural senior citizens makes me wonder why no one has tried to correct the system for the last 23 years. Even though some changes have been made, it is still not even close to being equitable.

WHAT ARE SOME EXAMPLES OF THIS UNFAIRNESS

The U.S. Government Printing office in Washington D.C. produced a Medicare Directory of Prevailing Charges for 1984. This document used facts and figures provided by the U.S. Department of Health and Human Services and the Health Care Financing Administration.

For example, the approved medicare charge for an open reduction of a fracture is $412.60 for a patient in the state of Massachusetts (suburb district) versus $2681.90 for a patient in New York (A district).

A urinalysis in Nebraska was reimbursed at the $4.00 rate. In Alaska it was $12.00.

Reimbursement rates differ in some cases as much as 700%. Please refer to exhibit number one for more examples. While these numbers were for 1984, the same disparities exist in 1988. They are just worse now and will continue to get worse unless something is done.

A WORD ABOUT SOME PERSONAL EXPERIENCES

When I began my medical practice 19 years ago, all I had was the microscope I used in my histology course in college, and a stethoscope and blood pressure cuff that the Eli Lilly drug company gave me in medical school. With a few more supplies I was able to do blood counts and a few urine tests. The hospital had an x-ray machine, an electrocardiogram machine and a spectrophotometer that could do a few blood chemistry tests. That is a far cry from what we have to have now. We were the first in our area to have a blood gas machine, a fetal monitor, and a second generation mammography machine. Now we have computerized medical records and billing systems. We have high-tech internal fetal monitors, automated blood chemistries, doppler ultrasound, state-of-the-art blood gas analyzer, high quality tomography, in-house holter monitor printouts, cardiac pacemaker programmers, and many other high-tech, state-of-the-art items of medical equipment. And even though we have contracted services for computerized axial tomography and real-time ultrasound, we still have to compete with the secondary and tertiary medical care centers and their NMR's and their Lithotrypsers and other high-tech equipment. When the Joint Commission of Hospital Accreditation (JCHA) visits our small hospital, they don't ask us what our reimbursement level is or whether or not we can afford high-tech equipment, they judge us right along with the largest and most expensive hospitals in the country. They are only concerned with quality care and the outcome from that care, not costs.

So when Medicare based their reimbursement on rural charges in 1963, they must have thought that I would still be using just my microscope and stethoscope as I did in 1969. Their reimbursement policies haven't taken into account the fact that most rural areas have also entered the high-tech medical era along with their urban counterparts.

Our patients have demanded that we continue high quality care.[12] Rural physicians have always wanted to give high quality care. And most of us have done so, even at the expense of our time, our health, our families, and our income.

But we can only be pushed so far. We are up against that wall. Thirty-nine percent of my patients are over 65 and account for 59% of my patient contacts, and 52% of my income. Medicare only pays about 55% of all patient charges. If I would take assignment on my medicare

patients, I would lose 25% of my income. And since my overhead is 77%, mandatory assignment would force me to move my practice elsewhere. That is not something any of us would want to do.[60]

WHAT ARE SOME HEALTH CARE STATISTICS FACTS

Thirty-eight million Americans will receive $307 billion in social security benefits 1988. Of this total, $88 billion will be for Medicare benefits. One hundred twenty-five million workers are paying into social security now. This means for every person collecting benefits now, there are only three people paying into the system. When it started in 1965, there were about 35 taxpayers paying in for the benefit of one person.

Part A is free for those that qualify and $234/month for those that have not paid into social security and therefore do not qualify. For their hospitalization, they pay a deductible of $540 in 1988 compared to $520 in 1987. After 60 days they pay $135 per day and after 90 days they pay $270 per day.[10]

Part B Medicare costs $24.80 per month compared to $17.90 in 1987. For outpatient services there is a $75 deductible and after that the patient pays 20% of the allowable physician charge.

The average USPCC (Unites States Per Capita Costs) for Part A is $136.44, and for Part B is $97.65. This is the cost of care for one patient for one month.

The ACR (or Adjusted Community Rate) that is used for contracts between Medicare and third party payers is 95% of the USPCC.[44] The ACR is that amount of money that Medicare will pay to a third party to pay for all the medical expenses for one medicare patient for one month. In reading your counties ACR in exhibit number four, if your ACR is $85.50, then Medicare will pay an HMO $85.50 to take care of medical services and procedures expenses for one Medicare patient for one month.[44]

The ACR in Minnesota ranges from $42.75 in Meeker county to $138.61 in Olmsted county. In the Twin Cities they are $84.88 for Hennepin county and $83.26 for Ramsey county. Most out-state counties average about $50.00 and the average for the entire state is about $79.00 which is far below the national average of $97.65 for Part B Medicare. The ACR for Dade county Florida is $192.16 which is about 450% more than Meeker county MN. This ACR, or Adjusted Community Rate, differential, very closely parallels the differential for reimbursement for our senior citizens.

Thirty-two states have averages far below the national average for almost all of their senior citizens and they also have a high percentage of rural elderly. In ten more states it affects a majority of its seniors. All states have some counties that are far below the national average.

Twenty-four percent of the population of the U.S. live in rural areas.

Twenty-nine percent of the population over 65 years of age live in rural areas.

Twelve point seven percent of the population in MN are over 65. Of the 4.35 million people in the state, 550 thousand are over 65. In the U.S. there are 30 million people over 65 out of a total of 246 million.

Physician availability for the U.S. is 163.3 per 100,000 people, while for rural counties under 10,000 there are 53.0 physicians per 100,000 people. This rural rate is about 1/3 the national rate.[4]

Medicare reimbursement for rural hospitals is 36.8% less than urban hospitals.

Fifty percent of the total Medicare reimbursement to Medicare patients is for services provided by only 10% of the physicians. The other 90% of physicians receive their reimbursement from patients who get the other 50%.[28]

Twenty-five percent of all physicians are considered "older" physicians. However, in rural America, over seventy-five percent of physicians are "older" and closer to retirement.

Canada reimburses rural physicians 5% more than urban physicians because of the skills and experience required and because of the more difficult circumstances surrounding the practice of medicine in a rural area. In British Columbia there are licensed physicians who are not practicing medicine because the urban area is at their quota and the state won't let any more physicians practice there. But there is a shortage in rural B.C. Rather than practicing in a rural area these physicians would rather not work or they want to look for a different job in the city. The U.S. Medicare system reimburses urban physicians 40% more than rural physicians, when similar specialities and similar practices are compared.

According to Richard P. Kusserow, Inspector General for the Department of Health and Human Services, in a recent statement before the select committee on aging, the 1986 profit rates for Urban Hospitals was 10.82%, while rural hospitals average a loss of 0.69%.[9] One out of 10 rural hospitals had a loss of 20% last year.[29] One hundred sixty five rural hospitals have already closed.

While there has been some PPS changes in reimbursement for rural hospitals, the wage adjusted published rates has only changed the rural-urban differential from 39.6% to 36.8% for equivalent DRG's.

The cost of running rural hospitals has increased more than twice the market basket rate in the last two reported years.

Health care is the number one business in Minnesota as it is in many states. Total United States health care costs have increased from 6% of the gross national product (GNP) for 1974 to 12% in 1988 and may be $500 billion this year.[47]

Health care costs are expected to triple by the year 2000.

A 257 page report from a Ralph Nader organization concludes that poor people of Minnesota have the best chance of getting adequate health care of any state in the United States.[26]

According to Kevin Fickenscher, Physician director of the Center for Rural Health Services in Grand Forks, ND, the elderly account for approximately 2/3 of the patients in rural hospitals as opposed to 1/3 in urban facilities.[24]

Rural hospital occupancy rate have fallen from 60% to 28%, and in hospitals with fewer than 50 beds, the average occupancy rate is 18%

Thirty-seven million Americans are not insured.[5] Forty percent of rural workers are under-employed. Rural counties while having 24% of the population have 50 to 85% of the citizens who live in poverty.

There are 5 million people living and working on farms. This is the smallest number in 140 years. Farmers receive about $27 billion in farm aid.

Rural Physicians see 20% more patients in their offices than do urban Physicians.

Persons 55 and older account for half of health care. By 2000, half of our population will be over 50 years of age. The over 65 age group spends over $120 billion a year on health care and this is 15% of their income. The average out-of-pocket money expense in 1980 was $1,060 a year and they visited the doctor eight times a year. The over-65 population will increase by 45%, the 75-84 group by 65%, and the over-85 age group by 52% by year 2000.[36] With these changes, physician visits will increase by 47% from 1980 to 2000.[8]

Unless changes are made, the Medicare Trust Fund is projected to stay solvent only until the year 2005 to 2008.[9,52]

About 1% of Americans 65 to 74 are always in a nursing home. Twenty-two percent of those 85 years and older are in nursing homes.

Over 400 hospitals in America have closed since 1980, and for 1989, it is expected that one hospital will close every 10 days.

Over FORTY BILLION DOLLARS has been re-directed from the Medicare budget and to national defense since 1983.

HOW DO THESE FACTS FINANCIALLY AFFECT SENIOR CITIZENS

When a physician in Dade County Florida charges $140 for a skin biopsy, Medicare may allow him a payment of $95, and the patient will rarely get billed the balance. When a patient in rural America has the same procedure done and the MAAC profile only lets the doctor charge $60 and Medicare will allow a payment of $40, that patient will get reimbursed only $32. That physician is forced to "balance bill" the patient. The perception by the patient is that it cost them much more for procedures in rural America than it does in a larger city. While this is only an example, it is really the way it happens. Rural senior citizens end up paying more out of their pockets.[58] In addition, since the maximum allowable charge is so low, rural physicians have to bill their non-medicare patients more to cover their overhead.[59] So all rural patients pay more. Factual examples of these reimbursement differences are listed in exhibit numbers one and two.

With the above facts proving a differential of 36.8% for hospitals and an overall average in ACR levels that vary 40% when comparing rural versus urban, and with HCFA's own numbers showing 40 to 50% disparity, most authors agree that a figure of 40% is close to being accurate when comparing rural and urban reimbursement. This does not take into account the fact that many urban patients don't have to pay a deductible because many of them contract with an HMO who often does not have to pay the deductible.[33]

With managed health care systems insuring up to 35% of the total population in some urban centers,[16] it is not difficult to figure out why HMO's are staying away from rural America.[16] Most HMO's are started up by entrepreneurs who only have one thing in mind--a profit. About 1% of our 32 million medicare patients[44] have enrolled in some form of an HMO.[17] It is easy to see why they are all located in areas that are reimbursed at a very high ACR level. Many HMO's have gone broke or have moved out of lower reimbursed ACR areas--they can't make any money there.

When consideration is given to the recently mandated catastrophic health insurance,[6] qualifying levels of out-of-pocket expense have been argued at from $1,100 to $1,850 per year.[54] Knowing the levels of average out-of-pocket expense, and the numbers of Physicians taking assignment, it appears the rural senior citizens are paying $480 per year more than their urban counterparts for their out-of-pocket medical expense. Twenty-nine percent of the 32 million Americans are living in rural areas. This is 9.28 million people. This amounts to 480 times 9.28 or $4.064 billion dollars of extra out-of-pocket expense. Total annual expense for each urban patient is $3940 and for each rural patient it is $2364 or 40% less. The difference is $1586, and $1586 times 9.28 million patients is $14.769 billion that Medicare is taking away from rural areas and is giving to the urban coastal cities. $14.769 billion and $4.064 billion is **$18,833,000,000.00** total that is being taken away from rural America and given to the large metropolitan areas.

With the number of senior citizens in Minnesota, this amounts to an extra $250,000,000.00 per year of out-of-pocket money that they are paying for their health care. And another **$.793 BILLION** is being lost out of the state each year because of the disparity of reimbursement. Therefore, the total is well over **A BILLION DOLLARS PER YEAR** that the state of Minnesota loses to the large coastal states. Nationwide rural citizens are paying an extra $18 billion more. Indirectly, this money ends up reimbursing those Medicare patients in urban America for their health care.

WHAT ABOUT MANDATORY MEDICARE ASSIGNMENT

Fourteen states have had attempts at establishing mandatory assignment. Ten have failed.[53] Four others have passed a law (Massachusetts, Connecticut, Rhode Island, and Vermont) and three have begun mandatory assignment.[43]

It is easy to see by the data in exhibit number four why Massachusetts was able to pass the law. The medicare patients and hospitals in that state are already being reimbursed over 20% ABOVE the national average. In fact they are being reimbursed 200% MORE than all of rural America.

It is also easy to see why the good senators and representative from the states of New York, Massachusetts,[50] Florida, and California are all pushing for mandatory assignment and national health insurance[5]---they have already made sure that their senior citizens and their hospitals have been reimbursed more than anywhere in the country. So no matter what the PPRC (Prospective Payment Review Commission) or the AMA-Harvard Relative Value Index study recommends to us in their final report, and no matter if there is catastrophic health insurance or a national health insurance---their states have an enormous advantage by already benefiting from 23 years of high reimbursement. And if any of these programs are accepted, without any changes in reimbursement policy, their states will continue to get the highest reimbursement---at the expense of senior citizens of the rest of rural America.

For Minnesota and the other 32 rural states,[46] mandatory assignment will only tend to reduce the quality of medical care, and to reduce the access to medical care for most, if not all, of those senior citizens.[58]

HOW DO THESE FACTS FINANCIALLY CREATE OTHER RURAL HEALTH CARE PROBLEMS

The recruitment of primary care physicians to rural areas is becoming more difficult every year.[59] Rural physicians see more patients, work longer hours, are on call more often, get paid less, have less free time, have fewer physicians with whom to consult with, and in general have to have more training and experience and be able to handle a wider variety of problems than their urban counterpart. Twelve percent of primary care physicians practice in the rural area and see 24% of all patients in this country, 29% of all medicare patients, over 66% of all medicaid patients and over 85% of the unemployed or working poor.[49] Eight percent of rural Minnesota Physicians indicate they will leave their practice in the next year or two.[43] Thirteen percent say it is only somewhat likely that they will continue to practice.[43] So retention of physicians in rural areas is also a problem.[15] It is more difficult to get "good" doctors in rural areas. [27] It is my perception that rural areas are attracting more and more doctors that I would not call "good" doctors.[15]

Many hospitals in rural areas are having a more difficult time in hiring Registered Nurses. There is a definite nursing shortage. The lack of proper medicare reimbursement for hospitals as well as for physician's clinics make it almost impossible to reimburse a "good" nurses as much as they can get in the "big city". Therefore, is is not only difficult to get nurses, it is also more difficult to retain good nurses in medical offices as well as in hospitals.[14]

It takes a physician with intelligence, excellent training, and experience to be able to withstand the vigors of rural practice. Our training programs are not turning out these kind of primary physicians anymore. They are graduating from programs that make them more dependent on peripheral support and "quick" consultations.[4] Because of higher Medicare reimbursement in large cities and large multi-speciality clinics, they will receive a much higher income if they stay away from rural areas.[22] And since none or very few of their medical school professors are rural oriented physicians, these professors tend to "steer" these students away from rural areas.[23] Minnesota is very unique and fortunate because of the Rural Physician Associate Program (RPAP) started by Dr. Jack Verby. This unique program has been responsible for supplying many physicians to rural areas in the upper Mid-west.

Because rural clinics see a higher percentage of patients who get reimbursed by medicare, they depend on this income to keep up with the high standards of medical care that their patients deserve. But with lower reimbursement for their patients and subsequently lower income for themselves, it is nearly impossible to purchase the high-tech equipment and medical and surgical supplies necessary to keep up with these standards. Consequently, I believe I am starting to see reduction in quality care in some rural areas.

According to Dr. Rodney U. Anderson at the annual meeting of the California Medical Association, the poor and uninsured were 27% less likely to visit a physician and 19% less likely to be hospitalized than were members of other groups, even though the poor were a sicker patient population. And in 1986, an estimated 1 million persons were actually physically turned away from health care for economic reasons, he said. If high quality medical care and ready access[61] to medical care are our societies main goals, than these iniquities[57] in reimbursements will have to be corrected as soon as possible.[33]

We certainly have a need for the new catastrophic health insurance[45], [31] for many of our senior citizens, especially in rural areas.[31] This need certainly would not have been so great[45] if these patients would have been reimbursed at a rate equal to the national average.[31]

Other problems such as the medical malpractice crisis, unemployment, and the lack of any health insurance in many rural areas, have been made worse because rural America has been shortchanged up to EIGHTEEN BILLION DOLLARS a year for last year, and a comparative amount for each of the last TWENTY THREE years. In most rural areas that have a hospital, that hospital and medical care system is usually the number one employer in the area. With medical care being the number one business in most towns and states, it's easy to see what a devastating effect this inequitable reimbursement can have.

If all of the above defined problems continue, then the Seniors of this country are going to hear about a new problem---The Nonprovider. There are already a few specialists that refuse to treat Seniors, and if inequitable reimbursement continues, there will be many more.

WHAT IS THE BASIC DEFECT OF THE SYSTEM

While you can argue that there may be some different views to the opinions expressed here, and while there may be some lack of agreement in the finite accuracy in the numbers stated above, the fact is, everyone will agree that there is definitely a large difference in reimbursement. The fact is, all Medicare patients pay exactly the same premium, but they get reimbursed at different rates and this just is not fair. If they pay the same premium, let them get reimbursed exactly the same. Otherwise charge that Medicare patient in urban America a higher Medicare Part B premium if they are being reimbursed more.[32]

If a Medicare patient wants to go to a physician in Dade County Florida where the standard of living may be higher, or the physician may have more liability expense, then let that patient get balance-billed for the difference in reimbursement. Don't force all of our rural senior citizens to, in effect, subsidize the urban patients care by paying more out of their own pockets.

THAN WHAT IS THE SOLUTION TO THE PROBLEM

It is so very simple. Since they pay the same premium, reimburse them exactly the same rate for their Medicare service.[30] Get rid of the payment disparity for the 240 different areas. Get rid of the payment disparity for the different specialties. Have only one payment schedule for all medical services.[30,31,32,33,34]

WHAT WILL THIS SOLUTION COST

Nothing. If all reimbursement was equivalent to the national average ACR, then there would even be a 5% reduction of federal Medicare costs. If this was done it could amount to a 22% increase in capital to the rural health care crisis areas. In fact, if we correct the loss for out-of-pocket money and the fourteen billion dollar reimbursement disparity, it could have a tremendous impact on all of the problems that we are having in rural America..

If a national Relative Value Index or a national fee schedules,[27,30,56] was used that had only one price for each service and if this price list was at the ACR or Adjusted Community Rate, and if all medicare patients who pay the exact same premium would get the exact same reimbursement, this would save the federal government 4.4 BILLION DOLLARS A YEAR.

WHAT IF NOTHING IS DONE

Then the senior citizens that are affected by this iniquity will continue to be treated as SECOND CLASS CITIZENS by the Federal Government and every State Government. And this will include all of the senior citizens in 32 states, most of them in 10 states and some of them in the remaining eight states. SOMETHING MUST BE DONE SOON.

Respectfully submitted,
Richard D. Mulder, M.D.
Ivanhoe, Minnesota

MEDICARE REIMBURSEMENT AND RURAL HEALTH CARE

by Richard D. Mulder, M.D.

All United States Citizens Pay exactly the same Social Security or F.I.C.A taxes. This entitles them to Medicare Part A, or Hospital Insurance benefits. All hospitals give the same quality of care and have to follow the same guidelines set up by the state, or by Medicare, or by welfare, or by the Joint Commission on Accreditation. They are all reimbursed a DRG, or Diagnostic Related Group, rate.

The rural hospitals in Minnesota and the rest of rural United States are being reimbursed at a rate of 37% below that of the urban hospitals, even though their patients have paid in the same exact tax.

Therefore rural senior citizens are being treated as SECOND CLASS CITIZENS by the United States Federal Government, and the state of Minnesota is losing two or three BILLION dollars a year because of this iniquity.

All United States Citizens Pay exactly the same monthly Part B premium of 31.90 so that they qualify for reimbursement for outpatient medical care and in-hospital medical services by a Physician.

The Senior Citizens in all of the state and especially those living in rural Minnesota, as well as all of rural America, are being reimbursed 40% less then are urban Seniors.

Therefore, rural Senior Citizens are being treated as SECOND CLASS CITIZENS by the United States Federal Government, and the state of Minnesota is losing over one BILLION dollars a year because of this iniquity.

The state of Minnesota has already lost two or three billion dollars a year the last twenty three years. And worse yet, all of rural America is suffering an annual loss of over FIFTY FOUR BILLION DOLLARS A YEAR.

If there is no change in this policy, there will be A REDUCTION IN ACCESS TO QUALITY HEALTH CARE FOR ALL OF THE CITIZENS living in rural America.

We must insist on EQUAL payments to all hospitals and EQUAL payments to all Senior Citizens since the pay the EXACT same tax.

Everyone must contact their senior citizen groups, their congressmen, and their state legislators and request them to take IMMEDIATE ACTION to correct this dangerous rural health care problem.

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